ALASKA HEALTH CARE COMMISSION

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P R O C E E D I N G S

8:00

(On record)

CHAIR HURLBURT: Let's get started on time, and I know several folks have some obligations this afternoon, so 12 o'clock is a hard departure, and a few folks something a little earlier than that. We should -- this morning, we have the first hour to talk -- continue our conversation from yesterday afternoon about yesterday's session there with the advantage of having time to (indiscernible - voice lowered) on it overnight.

Then at 9 o'clock, we have four areas we're going to focus on, on tracking recommendations from prior years, then a session on statewide planning initiatives and a wrap-up at the end. So Deb, I'll turn it over to you.

COMMISSIONER ERICKSON: We're just finishing getting the computer set up here right now, but while we take a couple of minutes to get organized, you each have a couple of documents that were just handed out that look really similar to one another. They have the same heading. But I wanted to make sure that you had in front of you a complete set of all of the notes from our brainstorming session on End-of-Life Care yesterday. So just as they came out and as I recorded them, they're in one bulleted document.

And then the second one that has the same heading, Our

Brainstorming Session Notes on Improving End-of-Life Care, I took a real quick stab this morning, in just a few minutes' time, and tried to organize and synthesize just a little bit. I didn't have time to do much synthesis, but organized a little bit those bullets that were really pretty random yesterday into those that pertain more to just kind of general finding statements and then those related to recommendations. And there wasn't time this morning to get those posted on the Web, for those of you who might be listening on the phone, but there is a copy of these handouts in hard copy on the handout table outside for folks who are in the room, if folks in the audience here are interested in taking a look at these, too.

Related to -- or under the recommendations, I started with Colonel Harrell's kind of three themes that he had identified early on. They were making sense to me as well for how we organized them. So just so you can see under the recommendations area, I tried to group things, as much as possible, around the communication theme, the standardization theme, and the incentivize theme. There were some issues that came up that I couldn't quite fit into one of those three themes. It seemed, to me, more related to additional services, such as the hospice house, the "No One Dies Alone" program. Distinct programs and services I put in an additional new kind of theme area list. And then there were a few things that I wasn't quite sure whether it was really

either a finding or a recommendation, but seemed to be some thoughts about general principles and that's a final category on the fourth page of that document.

So what I'm going to ask you to do for just the first three or four or five minutes this morning is take a look at these documents. You have, again, the bulleted list in the order that we captured the bullets yesterday, so you can -- if you feel as though, in my organizing things, I lost something or left something out or misunderstood it, you can go back and look at how it was captured on our slides from that document. But we'll see if we can spend some time this morning refining our thoughts around findings and recommendations, again, not wordsmithing. We're not going to wordsmith today, but if there are any important concepts that you want to make sure that we capture as we move forward with drafting, that's really what we want to get at today. Does that make sense? Does anybody have any questions? Thumbs up. Let's look at that for a few minutes while I make sure the computer is working.

(Pause - Commission reviews notes)

COMMISSIONER ERICKSON: So it looks like we're close to getting ready here. Some folks are still studying, but more and more of you look like you're done. So why don't we just start off with findings first? And I just want to make sure, if there is something on the existing list now, understanding

it's still really rough, that you want to emphasis, add some additional points to clarify on any of these existing finding bullets, and is there something critical that you think needs to be emphasized in terms of something that you learned yesterday or already knew, perhaps, that you want make sure is identified as an important finding for the Legislature and the Governor when they get our report in January? Yes, Allen?

COMMISSIONER HIPPLER: To me, one of the most important findings is that the entity that spends the money on palliative care may save money for the system, as a whole, but not realize those savings itself. I think it was stated as "cost savings don't accrue to the investing or subsidizing organizations."

COMMISSIONER ERICKSON: I probably should have numbered these. In hindsight, it would make it a little easier, but yes; that's the third bullet on the findings. So your comment, Allen, is that it's important to emphasis that. Other thoughts? Yes, Dr. Urata?

COMMISSIONER URATA: You know, I think POLST ought to be mentioned somewhere, and you know, I think it's another type of directive that's different from Advanced Directives and that's why 12 states have accepted it, but I'm not so sure that it needs legislative action, and I'm not sure if we should just let the current kind of waive of interest in that continue on its own and develop, but it is something that we

need to be aware of. It's a new movement about orders for End-of-Life Care, or aggressive care, if that's what the patient desires.

COMMISSIONER ERICKSON: So what we can do is make sure that we have a bullet, because I don't think we have it right now, in the findings related to standardization of forms and what some of the other states are doing. So we'll add a finding statement related to POLST, but then your question is more related to whether we should have a recommendation specific to that or not. So we'll continue that conversation in a few minutes and refine it. Yes, Emily?

COMMISSIONER ENNIS: Somewhere in the report, I believe we need to have a description or definition of palliative care. I think many people really don't understand. You know, we're talking about -- it's a part of hospice, but not hospice. It's not palliative care. So a definition or description for the report and perhaps even including a description of Comfort One, Do Not Resuscitate, just some clear understandings of the differences of these services and requests.

CHAIR HURLBURT: Could I ask, did you think the definition that Dr. Ritchie shared with us yesterday was a good one for us to use?

COMMISSIONER ENNIS: I probably need to hear it again. There was a lot of information, so I'll look for it. Thank

you.

COMMISSIONER HARRELL: It's a bit long and technical for my liking.

COMMISSIONER DAVIDSON: There's a really nice one in this book, and there are two lines at the end of page three: "Palliative care pays attention to the mind, body, and spirit of the patient and family. It begins with diagnosis of a life-limiting disease." So it does two things; it defines it and makes the point that it should start early in two, short sentences.

CHAIR HURLBURT: That's simpler than that.

COMMISSIONER ENNIS: And there may need to be a little more of an example, too. You know, examples of what is included in the care.

COMMISSIONER ERICKSON: What page was that on, Val?

COMMISSIONER DAVIDSON: Bottom of page three.

COMMISSIONER ERICKSON: Yes, Bob?

COMMISSIONER URATA: The only part I would disagree with is that palliative care can also treat painful, non-life-limiting diseases -- or life-ending diseases, such as rheumatoid arthritis, you know, chronic back pain, that sort of thing.

CHAIR HURLBURT: I like the more straightforward definition, but looking back at the one that Dr. Ritchie shared with us yesterday, it may have some significance that

that, apparently, comes from CMS.

COMMISSIONER ENNIS: Dr. Ward, I would agree, and I think what would be helpful is, because it does come from CMS, it gives you the scope of what will be funded.

COMMISSIONER ERICKSON: Well, maybe somehow I can work this so we have the general concept that's laid out in Christine's booklet and then take the CMS definition to refine, maybe in a sub-bullet. Does that -- okay.

COMMISSIONER URATA: I've always defined it as comfort care, you know, in a word. Stop suffering. Treat suffering.

COMMISSIONER ERICKSON: Other thoughts about findings? Anything critically important that's missing? Hearing none, let's move on to recommendations. So starting midway through page two, and again, I took Colonel Harrell's suggestion in terms of how to categorize into themes around communication, standardization, incentivize, and added a fourth, another catch-all, but it was more about additional services.

COMMISSIONER CAMPBELL: It strikes me that, under public service type announcements, stories, et cetera, we maybe should give some thought about how those could be financed, other than just the tobacco type things, but we're saying it should be done. Maybe we should fill out some ideas on finance. I don't have any particular ones because the funding for this palliative care is going to be hit-or-miss sometimes anyway, but if anybody has any thoughts about it. But I

thought, if we're going to make a recommendation, we probably ought to make some sort of an idea on how to find funds for these kinds of things.

COMMISSIONER URATA: You know, the thing about palliative care is that -- or tobacco is tobacco, I think, came from a grass roots movement. You know, the Cancer Society, the Lung -- there was evidence-based evidence that, you know, tobacco causes cancer, and it had a major impact in our society in terms of money and such. And then I think, subsequently, public health services took it on and then we got all these -- and then also there is money from the tobacco companies, themselves, that, in our state, we are able to use to educate people and try to reduce the problem with tobacco. And I'm not so sure that we have similar things with palliative care. You know, there is -- I don't see a large grass roots movement in that and so we're sort of approaching this from a different way or different, you know -- you know, I don't think it's coming from the people necessarily. I could be wrong and in the way I'm looking at this and simplifying what I see, but I don't know.

COMMISSIONER CAMPBELL: Well, I don't know either, but I just think that, sometimes if you want to recommend something, you ought to, at least, throw some ideas out how to get -- move them towards the goalpost.

COMMISSIONER HARRELL: So Deb, in terms of your comment

there, this particular piece didn't relate so much to the incentivization, but more to the public education. So how do you finance a public advertising campaign, basically, to make people aware of what's available?

COMMISSIONER ERICKSON: Yep. Thanks for that clarification.

COMMISSIONER HARRELL: Being ignorant to this, is the State able to approach the federal government for funding of this nature in terms of public service advertising? And I'm somewhat hesitant to say that again because the coffers are dry, but it is an issue of population significance. So that may not be an unreasonable thought.

CHAIR HURLBURT: I would say that, generically, everything we see shows federal resources getting tighter and tighter. There are still various grant options that come out, like still a number of things coming out in support of the Affordable Care Act, but generally, things are getting tighter. We're losing $18 million for our Office of Children's Services this year. And Bill Streur reports that every meeting he goes to with people reporting from both sides of the aisle say that it's going to be tough. So I think it's not going to be an environment, with the size of the deficit, size of the debt, to look for new federal initiatives, unless they are very specifically targeted to a high priority of whatever the Administration is.

COMMISSIONER HARRELL: Going along with Keith's comments, it seems reasonable that you could pursue grant money from private entities that relates to palliative care, and they would be very interested in publicizing this initiative. I'm treading into waters I don't know anything about though, so.....

COMMISSIONER ENNIS: I think that one of the reasons that the example of the tobacco marketing in the anti-use and anti-smoking is different from this issue is that palliative care is really, with exceptions, for our older adults, for seniors, and for people who are aging. So you have a distinct population that is bringing up a lot of new issues.

I would recommend that we consider, along the lines that Colonel Harrell just mentioned, even AARP and maybe the Alaska Mental Health Trust as we're looking for the beneficiaries that are experiencing Alzheimer's and other related disorders. But I think we are tapping a new area of marketing and information. So we should, at least, relate our sources for supporting this to that age group.

COMMISSIONER HARRELL: And just for clarification in terms of bringing up the tobacco piece, the part that was pointed, to me there, is that the new tobacco series, as you all know, is very personal. And so again, Ms. Palmer's comments about "I'm a person, not a battlefield," that personification, bringing a story to it is what really engages

people as opposed to a series of facts. So that's why I brought up the tobacco piece.

COMMISSIONER BRANCO: The Surgeon Generals have weighed in periodically over time, with C. Everett Coop with tobacco cessation and warnings to the public. Jocelyn Elders stuck her finger into the contraception, and there was early identification of sexually transmitted disease. This might be one that we tee up with our current Surgeon General.

As Dr. Ritchie pointed out, she used the rat and the snake. I prefer the pig and the python. Exactly what Emily was saying, this generational evolvement of a large number of folks entering that age when palliative care will become much more important in the continuation of our lives. And as one of the previous Commissioners, Noah Laufer, used to say, "ending life as the hero of your own life." I just love that phrase that he used often, allowing people to transition there. It might be one in which we can generate a letter to the Surgeon General and ask for dollars, focus, energy, and attention.

CHAIR HURLBURT: Keith?

COMMISSIONER CAMPBELL: Well, getting back to Allen's point about number three, that the cost savings is necessarily going to be to the system, as a whole, it seems like -- if we looked at a public education type thing, it ought to be geared from that overarching beneficiary, which is the general public

and the patients, so from a financing standpoint or whatever. So if the system is going to benefit, the system somehow ought to, if it's important, come up with a method of getting this message out.

COMMISSIONER BRANCO: (Indiscernible - away from mic)

COMMISSIONER ERICKSON: Oh, very good.

COMMISSIONER HIPPLER: Well, I hate to be unpopular, but should the government be in the business of marketing services that, in the opinion of certain people in the government, are underutilized?

We think that palliative care is currently underutilized and that, by a greater utilization of it, the system, as a whole, could save money; I understand. Making the bridge to it is then the responsibility of the government to tell individual citizens how to seek care -- or not tell them, but advise them is, for me, a bridge too far.

COMMISSIONER ERICKSON: I was just going to encourage Allen -- I guess we don't need to do that -- that he doesn't need to be shy, but I think it's a real valid point, and we alluded to, yesterday, what happened at the federal level when this conversation happened, and it was because -- you know, some people think that it was because other people were just being unreasonable and not understanding the issue, but I think, at the core of it, some people have a valid concern about whether government should be involved and how government

should be involved in making decisions about anything related to beginning or end of life. So Val and then Bob and then Ward.

COMMISSIONER DAVIDSON: So I guess I think palliative care is happening already in a variety of settings. It's happening in hospitals, it's happening at communities, and it's happening in individual homes, but often, in many cases, it is not happening well. People don't -- people who are doing it already, family members, community members, or in the hospital, may not necessarily know -- well, hospitals should know, but in the community and individual homes, people are feeling very alone and unsupported, and I think, when we were talking yesterday about an education campaign, I thought what we were talking about was getting the word out to people that there are resources that you can call, that you can help -- that you can call in the middle of the night or whenever to say, this is my situation; do you have any advice for how I can do this better? Or somebody who calls and says, I haven't slept in three days; we've been doing this 24 hours a day. Can you help to guide me through this process? I thought that's what we were talking about because it is happening right now. It's just not happening well in many situations.

(Pause)

COMMISSIONER ERICKSON: Can I insert a follow-up comment to that, too, because one of the other things we talked about

in terms of education was about the importance of personal planning and had the wonderful guidebook that Jenny had written with the support of the End-of-Life Care Foundation in Juneau and the Rasmussen Foundation, something that you all got a copy of last time. I don't know if you had time to study it, but another support for another aspect, not just accessing services.

COMMISSIONER URATA: So Allen, I don't think you're unpopular. You just said something that maybe not everybody agrees with, but I tend to agree with what you're saying. At this point in the process, I'm not so sure that the Health Department for the State of Alaska should take lead and start putting out public service announcements, like the tobacco public service announcements, although they're very effective. The tobacco announcements are very effective, I think.

You know, that's what I was trying to say earlier about, you know, this should be a grass roots movement because there are, clearly, groups of our country who, for some reason, don't agree with our position and that's why Medicare -- in the Accountable Care Act, a discussion of End-of-Life Care was removed because it was thought to be a death panel discussion. And so you know, clearly, we need more education and such, but perhaps the American Cancer Society, AARP can start this educational program, and then later, government can be involved. Or maybe somebody, like the Surgeon General, can

start this campaign, but I guess, if we all agree or there is some compelling argument, the State of Alaska can start some sort of educational program for our citizens in our state, but.....

COMMISSIONER ERICKSON: Would it be inappropriate to ask somebody in the audience to -- if we're catching her off guard -- share a little bit of information because I know that there are campaigns and programs that have been put together regarding supporting people to have the conversation about End-of-Life planning? I don't know if that goes into what's available to them in terms of services and support at the end of life, but Donna, would you mind sharing a little bit? It might help this conversation.

MS. STEPHENS: There are communities in the country. One is in Wisconsin. It's called Respecting Choices. It has done a lot. There have been a lot in the world about how do we get people to talk about End-of-Life issues, and I think, when I've thought about palliative care and education and End-of-Life issues, I really see two distinct kinds of information that need to be given.

Hospice of Anchorage has looked at, with our board and strategic planning, what needs to be done in Anchorage and our state, and we believe that people need to have the conversation about what do you want at End-of-Life and would like to figure out how to make that campaign board, so that it

doesn't offend either end of the spectrum, that it's really about individual choice. And at hospice, what we do when we go into work with the family is ask, what are your goals? What do you want?

Some of the hardest times are when a family doesn't want what the provider wants -- as a nurse, how I would want to die -- and the family chooses differently. We support our staff and educate our staff to make sure that we are always honoring the patient, not what we, personally, would want. What does that family want, the goals? And I think that's what the End-of-Life conversations, planning ahead, need to be about is helping families to articulate before they're in crisis, before they're at the emergency room door, what does End-of-Life -- what do I want it to look like for me? And that rat is just bigger and bigger, and the impact on the system is huge, if people haven't had that conversation because we don't think well in crisis.

So that would be the conversation that I think is most important to controlling that quality and cost value. We know that people who don't have the conversation, that that's where the PTSD and the problems develop in the families after a death. We know that's where the tremendous expense is, and the research has shown that.

COMMISSIONER URATA: Question: do you think the State of Alaska should legislate some money for our health department

to start an education program on this?

MS. STEPHENS: No. I'd like them to give it to me. I would like -- we would like to be funded, frankly, for a pilot project. I think we don't even know -- we would need to start at the very basics. What's the message that people would listen to? People don't want to talk about death, you know. I'm so pleased that all of you are willing to and how many have come to hear, but people don't want to talk about it. How would we even incentivize people to listen and do Advanced Directives?

In Wisconsin, they had a quite small, tightknit community of hospital physicians and the community members themselves that was small enough to get this going, but it's going to be challenging. We're such a multicultural state. You know, our spiritual beliefs are diverse. How to do this in a respectful way, I think, is going to take some research and education and experience. And I think Hospice is a great place because we've been here for 30 years. We're independent. We're not connected to anyone, but that's my lobbying. I'll stop.

COMMISSIONER ERICKSON: Dave and then Colonel Harrell?

COMMISSIONER MORGAN: I guess I'll -- I don't know if this will make me unpopular, but it will, at least, move me midway between my friend Allen.

Sir Richard Burton, a great Shakespearean actor, said, on his death, "Death is easy. It's comedy that's hard."

I guess the real question here is -- and this is what we're all dancing around. You have "X" dollars to do this means someone has a minus and this will have a plus and that's the continual balancing act.

Listening to statements through the whole state budgeting processes, basically, we have a finite amount of money. So whatever is done by the State, we have to go on the assumption, or at least I do, that you have just so much money, and if, like a balloon, you push it out here somewhere else, it's going to have to be less.

Now personally, because I've done a lot of home health cost reports for Medicare -- and virtually, the two that I did -- one for four years in Bartholomew County in Indiana and one here in the state, it is provable that it's cost-effective, just the number -- if you just take the number of days that they're not in the bed versus the days they're in the hospice, it is very cost-effective from a strictly financial standpoint. It is good medicine, I think, from what I'm hearing from the physicians and from the witnesses, but we all have to accept -- I do -- that the balloon, more than likely, is not going to get bigger.

So I think everyone in the room, and even by our plan, sees this as an important part of what we're doing here and an important part in findings and recommendations, but we all, I think, or at least I do -- again for the third time -- is we

have "X" dollars. I think it's dollars, personally, well-spent, purely from a financial standpoint and as a someone who has had a grandmother, like probably everyone around this table who has had close relatives, go through hospice. So whatever that is worth. I'm probably not saying anything that no one in this room doesn't know, but hey, I have to say something, right?

CHAIR HURLBURT: I want to -- okay.

COMMISSIONER HARRELL: So to Dave's comment, yes, money is constrained, but that should not prohibit us from pushing forward an idea that makes sense and allowing it to be part of competition and allow the Legislature and/or the public to decide where they want to put the money. So I would not want us discouraged from generating this discussion and option and then allow it to be pared down, if it has to be pared down, because of fiscal realities.

The earlier failure of End-of-Life Care resulted, in my opinion, from, you know, the death panels because it was focused on euthanasia, and you made a very good point yesterday regarding the distinction between DNR and Allowing Natural Death. And so what we're really talking about here is education as opposed to decision, and the failure before was because it was mostly publicized as a result of decision, not education, and that makes a big distinction in terms of how this is received. I think most people would agree that

comfort and palliative care, as it's been described here, is universally accepted from the perception of mercy, so I think that would not be a very hard sell as long as it's put forward properly.

And then Allen, I find myself in an intriguing philosophical situation because I am for smaller government. Nevertheless, it is the government's responsibility to promote the general welfare, and therefore, this is a reasonable thing to consider. Now whether the government pays for it, which is probably unlikely, or whether the government then engages private industry to the importance of this is up to, again, the people to decide where they want to put their money, but I think it is the government's responsibility to promote general welfare of the populus, and it should have a voice in that.

CHAIR HURLBURT: Allen, on your comments, I would, personally, be unhappy seeing government step in and tell private practice physicians, like Bob and Larry, how to practice medicine and what they need to do, even if they're telling them to do something that clearly should be done, like 30 years ago when we didn't do a very good job of doing beta blockers after a heart attack, and we do a pretty good job now. That's not the role for government, nor do I think they should tell health insurance plans or employers what they should cover in terms of a benefit, but government also plays a big role as a buyer of health care services for employees,

for retirees, for Medicare and Medicaid. So it's a huge buyer.

And where we're faced with the reality of a $5 billion unfunded deficit for state employees for health insurance coverage that has been promised to them, I think government -- it's appropriate for them to act as a prudent buyer. And if the more use of appropriate palliative care is both the right thing to do from a standpoint of compassion, of quality care, and cost-effectiveness, then seems, to me as a buyer of health care services, whether it's as the employer or for other programs where they're entrusted with the taxpayer dollars, that's different than just decreeing how the whole system would be. That may be a nuance, but I really do look at it in two different ways there.

And I think that, on David's comment about resources, it's absolutely true in our department, and it's not that we know that it's going to happen, but because of the reality of the environment -- the process we go through is, in July, we begin the initiatives and make the requests for any budget increases, which has been the heritage to go to the next legislative session for the following July. Bill Streur, this year, instructed us in coming back to the second phase, by saying, we now have these requests. The second phase, which was providing some advice to him, is okay. If there is no new money, what can you give up, if this is that important to do?

And we don't know that that's going to be the reality or not, but I think that, as David was commenting, we have to recognize that world. So if we find something that's desirable to do, we have to be willing to try to identify, what can we give up? We can't just keep making the pie bigger and bigger, whether it's all government or health care.

COMMISSIONER ENNIS: Recent national data shows that, at least, 50% and sometimes up to 70% of End-of-Life Care is being provided by family members for various reasons. One, families want that. They want to provide that care as long as they can. Secondly, it's impossibly expensive for some families to obtain out of home care. And then thirdly, particularly in Alaska, there are no available resources.

There are no vacancies in our assisted living homes or there are long, long waits in our pioneer homes. So the responsibility, inevitably, falls to a family member. And we're certainly seeing the impact of that now in Alaska with our growing senior population. It's only going to get worse everywhere. The government is not stepping in to create additional out of home placements. Assisted living homes, nursing homes, all of that, you know, doesn't pencil out well for government or for the private industry.

So I think we do need to accept the fact that, for the welfare of our state, the welfare of our country, we need to prepare our families for this daunting task and for the impact

on them long-term. So education is certainly the first step in that preparation and support. Funding has to be there, too, for the other services that go in and assist those families, but education and making sure they have the tools for this difficult job and making it a positive job for them is so very important.

COMMISSIONER ERICKSON: One of the things -- if we could move off education -- we want to make sure that, if there are any other critical points that are missing or need to be clarified related to recommendations, we have some direction for working on that over the next couple of months.

But Dr. Urata, you had brought up the question about POLST and whether or not we make a recommendation related to legislation, and one of the other things that we didn't have enough time to spend with our expert local panelists yesterday was hearing from them about their more specific perspective on whether that's needed or not, and I do know that there is a group in Anchorage here that's beginning to investigate that question. And so maybe what we need to do is gather a little more information and get some perspective from them that I could share with all of you over email, so it might help with your thinking a little bit about whether, in our report, we make a recommendation that there should be a revision to state law or not related to the POLST/MOLST forms and that would fit in our standardization section. I'm seeing heads nod around

the table, for folks who are on the phone. So we will do that -- and a thumbs up.

Other important points related to End-of-Life recommendations you want to make sure we emphasize as we move forward with refining these statements? And if not, I wanted to see if any of you had had a chance to take a look at some of the other slides in your packet last night. Yes, Jeff?

COMMISSIONER DAVIS: Thank you. A couple things. I would like us to capture Emily's point that, perhaps, you know, thinking about the debate between government doing things and not doing things, but to, you know, think about the data points she just gave us, 50% to 70% being provided by family members. Maybe the communication is really focused towards resources for those families, what is available, those sorts of things and that would be, to Val's point, a way to help and to support and to make sure that things get done well that are happening today. So that's the first point. I'd just like to capture that.

With POLST/MOLST, when you do send something out to us, please make sure you give us a little more information about what it is. I'm not clear. So that would be helpful.

COMMISSIONER ERICKSON: It was in the 50-page handout amongst the two inches of materials you got in your notebook, but that you didn't get because you're.....

COMMISSIONER DAVIS: The notebook that I did not get.

COMMISSIONER ERICKSON: Yeah.

COMMISSIONER DAVIS: I'll read that at the break.

COMMISSIONER ERICKSON: There actually is -- in your notebook and posted on the website now, we actually have a link to End-of-Life Care handouts on our August meeting, but we have a focus area set up with all of the resources that were in your notebook are now linked on our website under the End-of-Life Care page, and we have -- if you don't want to read the 50 pages, there is a two-page briefing. Both of them are by AARP, describing MOLST programs and really a very useful resource. We really appreciated getting that.

So one of the things you all asked for earlier this morning in the finding statement was a description about what POLST and MOLST is and so we'll include that, as well as a little bit of a discussion about what we currently do in Alaska related to those forms. So we'll make sure we clarify that. Thank you.

COMMISSIONER DAVIS: Thank you.

COMMISSIONER ERICKSON: Yes.

COMMISSIONER DAVIS: Can I finish?

COMMISSIONER ERICKSON: Yes. I'm sorry. You may.

COMMISSIONER DAVIS: So under standardization, there was a conversation about a central repository, and it's more of a question and an idea. I wonder if the Alaska e-Health Network, as that stands up, could that become a central

repository? And we don't have to create something new, but that just becomes one of the functions of it.

And then under incentives, I think it would be important to capture Dr. Hurlburt's point regarding the State as a purchaser, that we can have significance influence on what the market looks like, if they're figuring out how to put incentives in their plans, that.....

COMMISSIONER ERICKSON: I'm sorry. Could you state that over again?

COMMISSIONER DAVIS: Sure. I'm happy to.

COMMISSIONER ERICKSON: I was still typing up electronic registries.

COMMISSIONER DAVIS: Sorry. You can't do three things at once? Come on.

COMMISSIONER ERICKSON: Unh-unh (negative).

COMMISSIONER DAVIS: So I think Dr. Hurlburt's point about the State as a purchaser is really important because, if Medicaid and the State (indiscernible - voice lowered) active plan are figuring out ways to incorporate payment for palliative care in a way that makes it make sense, you'll see action follow after that. So I'd like to capture that as part of our recommendations.

And then just one final thing. I was intrigued by Christine DeCourtney's description of the four phases of the ANTHC work that she is involved in, and I would love to have

kind of a report out when that's finished as to what that looks like. I think that would be instructive, if we could do that. Thank you.

COMMISSIONER ERICKSON: Val, do you know what the timeframe for that initiative is? It wasn't clear, to me, from her presentation yesterday.

COMMISSIONER DAVIDSON: It should be pretty soon, but I'll double check, and I'll make sure that she can do that, and I think you mean SOA.

COMMISSIONER ERICKSON: I'm sorry. What?

COMMISSIONER DAVIDSON: Replace the "D" with an "S" after Medicaid.

COMMISSIONER ERICKSON: I guess "DOA" means different things to different people, huh?

COMMISSIONER MORGAN: I can only say, wonder who is going to get a rack audit next?

COMMISSIONER ERICKSON: I will spell out Department of Administration. Any final thoughts? Yes, Colonel Harrell?

COMMISSIONER HARRELL: Just one final one. Agreeing with Dr. Hurlburt and related to a point we made yesterday, as a provider, as a physician, I would want to make certain any recommendation we put forward is in a language that is permissive to the provider as opposed on the provider. For me and for other physicians and those that provide care, that's an extremely important point. We do not want to interject

ourselves between the provider-patient relationship. I think that's a foul when you do that, so I'd, personally, like to see that emphasized, if there is going to be any kind of legislative suggestion that the language be permissive in nature, not restrictive in nature.

COMMISSIONER HIPPLER: In our draft findings here under incentive, one of the bullet points is "require palliative care and medical license." Would you consider that to be restrictive, Colonel?

CHAIR HURLBURT: That was a point Deb made yesterday. This was a suggestion that it could be the State Medical Board would want to consider that. A number of states have required, as a part of their continuing education requirements, that all states require for licensure renewal for physicians they have to continuing education and then a number of states have required specifically a certain number of hours of training related to either pain management or palliative care, that it's been recognized as something that they felt would be beneficial. So as a part of the benefits of the license that the state gives to the physician to practice, they're asking that they expose themselves to a certain number of hours of education in those areas.

COMMISSIONER HARRELL: Yeah, and I would not consider that restrictive. Mandate, yes, but not restrictive because you're not telling a provider, this is how you're going to

practice your medicine. What you're doing is saying, in order to receive your license, we want to have awareness of education on this issue. So it is a mandate, which you could certainly perceive as being another straw on the back that eventually breaks because of so many other mandates that we're required to follow, but I wouldn't view it in the way that I'm trying to imply here. I don't want any entity to tell me and my patient how we negotiate through a health issue. I want to be free to make that decision.

COMMISSIONER ERICKSON: Wes?

COMMISSIONER KELLER: On the recommendation about going -- you know, stop using the term "Do Not Resuscitate" to go to natural death, I'm wondering about the wisdom of that from a political perspective, you know. I mean, DNR has been around for a long, long time, and we may be through that political wave issue, and I think this might just mark us as being part of that discussion. We're really not. I mean, at some level, we're not, but I just wonder about the wisdom of putting that one forward because we don't -- you know, the question is, why are we doing it? You know, is there a hidden agenda? I can just see these kinds of things.

There are two pressures politically. One, from the perspective you point and that is domineering in mind, is the State is a provider -- a purchaser of medical services. We look at it that way, but you also have the reality of the

pressure that comes from the people wanting services, seniors specifically, you know. That's kind of a parenthetical. The real question I'm raising -- and I don't have a real strong opinion, but I just wonder if we really ought to go there, you know, in this last one.

COMMISSIONER URATA: You know, I don't think that we really need to go there. I don't think it's, you know, something that -- it may be too late because everybody is used to the word "DNR," but one way of describing DNR is to say that, you know, we're going to allow a natural death, and "allowing natural death" are some of the words I use when I discuss a DNR order with patients. And so if you break your leg, we're going to fix that. I mean, that's what I would consider doing, or at least, we'll talk about the options.

Now in our hospital when you go to surgery to fix your leg and you, you know, have a DNR order, that DNR order goes off. It's suspended during surgery and the immediate post-op period because we're doing surgery and we can induce a cardiac arrest, you know, if you have an allergic reaction to the anesthesia or something of that nature. And so we're going to resuscitate you, so the DNR order is suspended. And then we'll fix your leg and go through rehab and go on. But that's another way that some people will find more accurate or gentle in describing a DNR order. So it may be considered a tool or a way of discussing that order to a person.

COMMISSIONER KELLER: Yeah. I certainly didn't disagree with the concept. Maybe it would fit better under the education/communication rather than a specific separate recommendation.

COMMISSIONER ERICKSON: Colonel Harrell? And then we need to wrap up this conversation because we're at time.

COMMISSIONER HARRELL: I certainly would agree with that in terms of an education piece, but it's such an important distinction that I have not been able to verbalize, but had this discussion, when my mother was dying, with my dad. He was afraid that they would not do anything, and we had to have this discussion, but I've been able to articulate it concisely. And so I think it's important from an education perspective.

COMMISSIONER ERICKSON: Well, let's wrap up now because it is 9 o'clock and we don't have a whole lot of time this morning. If any of you have any particular points you want to make sure get made in those other -- from other slides that we were going to try to take a little time this morning to review, catch me on the break and let me know, and we'll follow-up over email on all of this in preparation for our October meeting when we'll spend time defining everything and have all of the documents out in draft to you a couple weeks in advance for your review, for that next meeting then, too.

Any final comments or questions before?

COMMISSIONER STINSON: (Indiscernible - away from mic)

COMMISSIONER ERICKSON: Oh, to palliative care, CME? Okay.

COMMISSIONER STINSON: And/or pain management. And when I was on the State Medical Board, those two issues were always the two number one issues that came up for physician providers in the state, and actually even though it's not part of licensure in the state of Alaska, as the board, we required several people to have retraining in those areas.

COMMISSIONER ERICKSON: Thank you. Next on our agenda is an update on some of the areas that we've made recommendations in the past, and I believe -- I don't have the agenda in front of me. Is the first one you, Dr. Hurlburt? Specifically on a particular area of -- thank you, sir -- workforce development that was related to a recommendation that the predecessor to this group that we picked up all of our -- the 2009 recommendations from the first Health Care Commission that was established under Administrative Order by Governor Palin -- one of the recommendations was related to the need for a state program for loan repayment and financial incentives as a recruitment and retention tool for health care providers, and HB78 was a law that was just passed this past session that now creates this program, and Dr. Hurlburt's staff in the Division of Public Health are going to be responsible for administering it, and they're in the process of working on a set of

regulations to implement it. So he's going to update us on that specific topic right now.

CHAIR HURLBURT: Based on the perception that has been a shortage of providers in certain areas, the Health Care Commission and ASTHMA, the State Medical Association, took a look at that. There was a consultant from the University of North Carolina, I believe, who was up here about not quite three years ago talking about that, and it looked at that nationally and had a finding, which was quite credible, to me and I think both the Commission members and ASTHMA, at the time, that, if you want to get providers in, in certain areas, in certain specialties and get them quickly and get them at the most containable cost, the best thing is with a loan repayment type program because, if you start funding medical students and residents and so on, people can change their minds, and if you need family medicine docs, they may decide to become an orthopedist or an neurosurgeon or something else. But with the loan repayment program, you can target if you're looking -- for example, if you're looking for family medicine docs, you can target locations if you want to get them in hard to fill areas, and you can get them in there quickly.

So there has been the loan repayment program. We've had some federal dollars for that, but the Legislature agreed that there was a need for more providers, and so, as Deb mentioned, House Bill 78 was passed in this last legislative session.

That's within the Division of Public Health, and we have made a commitment that we will be ready to go by January 1. We are on track for that.

There has been another loan repayment program in place called The SHARP Program, Supporting Health Care Access Through Loan Re-Payment, and that has had an Advisory Board, a community-based Advisory Board, that has been quite functional, that's worked well. And so the Commissioner approved, at least on an interim basis, using that same board to advise on House Bill 78. They have now had three meetings in the past few weeks, making recommendations, making some policy determinations there on that.

Under House Bill 78, practitioners -- there are what are called Tier I, Tier II. Tier I are dentists, pharmacists and physicians. Tier II are dental hygienists, nurse practitioners, RNs, physical therapists, physician assistants, psychologists, and LCSWs. There are some categories of providers that are, obviously, not included, and there would be advocates for those, but those are included in the legislation there.

Then under Tier I and Tier II, there is a breakdown on hard to fill and very hard to fill locations with higher loan repayment. For Tier I, the loan repayment amount is $35,000 a year. For regular placement and very hard to fill, 47. For Tier II, 20,000 and 27,000. The loan awards will be for an

initial three-year period of service with a potential renewal for a period of three years, and a re-application period of six years is possible. So a lifetime maximum of 12 years is within the legislation.

I won't go into a whole lot of other details. The fiscal note was $2.8 million with about $2.7 million identified for loan repayment and direct incentive payments, the balance being for the administrative costs for the program.

As I said, we have had the SHARP program in place, and as I mentioned yesterday in another context, in that program, we have had three or four instances where somebody had a health problem, for example, in one case, and needed to back off, wanted to stay, and we were able to accommodate that and would extend their period of obligation. There were one or two situations where somebody felt it wasn't working out for them, and in that case, we were able to stop the payment and recover any funds that had been advanced. But there have been four individuals -- now five -- who have completed their initial payment program and that's one that didn't extend as long as House Bill 78, but in each of those cases, in every one, that provider decided to stay for now, not necessarily for a lifetime, but for now, in the community and that's the vision.

The vision is that you can do a good enough job of matching the community and the provider, so that you're enticing them to come. Then obviously, the community has to

do some wooing because providers are hard to come by, that the fishing is good and make sure they get an opportunity to go fishing or whatever. But then hopefully, they'll plant their roots and will stay, hopefully, for a whole professional lifetime, at least beyond that. So that's about where we are.

COMMISSIONER ERICKSON: Does anybody have questions for Ward?

COMMISSIONER MORGAN: It's not so much a question. I did go down -- being the proverbial "show-er-upper," I did go down for their first meeting on this, and it was very open, I mean, even though they were appointed and a group was there. By going to the website, you could call in and talk, and it was a very fair and open process, but it was also a very directed process of getting this thing up and going fast, and I think they did a really good job, from what I could tell and what I've heard them saying.

CHAIR HURLBURT: Yeah. I'm on the line with my boss that we're going to make it, so.....

COMMISSIONER ERICKSON: If there aren't anymore questions for Ward on the HB78 regs, Melissa, do you want to come up? While Melissa is on her way up to give us a status report on implementation of recommendations we made this past year related to population-based prevention for behavioral health issues, I included a slide with an update for all of you, and also in your notebooks, it included just a printout from the

website of the new pediatrics program. And just again, as a reminder, one of our other workforce-related recommendation was specific to fostering the education of primary care physicians in Alaska and the need for support of primary care residency programs. And so this is just an update, since that recommendation in -- not because of it, but since the time of that recommendation in 2009, we do have this new pediatric residency track here in Alaska, and some of the details of the details about that are laid out on this slide, the new class. The first class just started this past month, and there is some exploratory work still underway in both Fairbanks and MatSu regarding development of new family medicine residency programs in those two communities.

We had followed the work to develop and implement a psychiatry residency program here in the state, and it's a program that, because of the cost involved, would require, or at least there has been a request, for state General Funds to support development and subsidize, over time, that residency program, and those two requests that went forward the last two years have not been funded by the Legislature at this point. So just a very quick update on that, and if -- yes, Keith?

COMMISSIONER CAMPBELL: I don't see the internal medicine residency program we had talked about some time ago, trying to encourage (indiscernible - simultaneous speaking).....

COMMISSIONER ERICKSON: There has not been interest, to

our knowledge, on the part of the internal medicine community in developing a residency program at this point.

So if there are no questions related to the residency program, I've put on the screen on this end, just as a reminder, the specific recommendations from our 2011 report. Again, this was specific to -- we were having a conversation, for our new members, about population-based prevention and recommendations related to outcomes and population-based prevention that the Commission could make, and we targeted the three top areas we thought were the most important at the time: obesity, immunizations, and behavioral health. And these are our two recommendations related to improving population-based population health in the behavioral health field or area, and Melissa Stone, the Director of the Division of Behavioral Health, is going update on the status of those.

MS. STONE: Good morning, I'm Melissa Stone, the Director of Behavioral Health. It's nice to be here and see you again.

When I was with you in June of 2011, the focus of our conversation was on four areas that I thought were significant in our behavioral health system in the state of Alaska, and we focused, if you remember, on family violence, on alcohol and other drug use, suicide, and mental health issues. So I wanted to give you a bit of an update on some of those areas from a year ago.

Relative to family violence, I appreciate the opportunity

to continue to be on the Council for Domestic Violence and Sexual Assault, which gives an opportunity for behavioral health to, I think, continually ask and impact the system of intervention in the domestic violence services in the state, and there are a couple of things that are happening now that I think are positive.

One is an increased outcomes orientation relative to Victim's Services evaluating their outcomes in what they're doing. That's a conversation that's happening now between the Council and Victim's Services agencies and the council members. So looking at the helpfulness of services to the victims relative to safety resources, isolation, legal rights, and other issues, I think, helps to really make sure that what's happening has a positive impact in making sure that we're looking at the impact of services on outcomes.

We also, in the Division of Behavioral Health, RSA funds from the alcohol tax money to the Council on Domestic Violence and Sexual Assault, and it recently occurred to me that that's a good opportunity to, frankly, leverage to see that, within the Victim's Services system, there is attention to alcohol and drugs as an impact with both the victims and the perpetrators. So we're having a conversation about what kinds of expectations we might have around that fund of money, and I think that's a positive conversation to have, again, to bring and to better highlight that alcohol drugs are a feature that

needs attention relative to family violence.

Some of the things that we have in process are very much in process. I think you're probably aware that, in the legislative session last year, we had been given the opportunity for an increase in alcohol tax funds to come to the Division of Behavioral Health over a three-year period, and we're in the process of examining what some of our features might be for those funds. Those decisions haven't been made, but I would say that the concern about and the opportunity for medication-assisted treatment is something that is under consideration. We're concerned with the current status of detox services and that's something that we have an opportunity to examine further with these funds.

We're in a particular problem right now relative to our medically-managed detox, medically-monitored detox in that we reviewed our providers and determined that, indeed, the services being provided are at a medical level, but we have some difficulty right now with the Board of Nursing that we're trying to work out relative to translation of requirements for what an LPN can do within their scope of practice. So we're at a difficult spot, working out the needs for registered nurse versus LPN and then what practice will allow within that in order to be able to ensure that the right level of care and right competencies are brought to these folks.

We talked, when we met before, about trauma-informed

care, about adverse childhood experiences, and the impact of that, which I think, regularly, we hear more about. Our trauma-informed training throughout the behavioral health system continues and is growing. More people are attending those, people from the behavioral health systems, people from the DV shelter systems, people from Office of Children's Services, a division of Juvenile Justice. So as we develop those trainings, we're getting kind infiltrating and influencing more of the systems of care who come to those trainings.

Trauma-informed practice is about what a practitioner does relative to working with an individual as well as how a system treats people relative to policies and procedures and expectations. So there is also change happening to trauma-informed systems of care, particularly at API, and recently, there was a conversation about that within Juvenile Justice. We also have an increment in FY13 in the Division of Behavioral Health for an expansion of trauma-informed care that we're working on.

Relative to some of the issues of integration, we have several systems examinations in place or in process. We are currently working with a consultant to look at acuity and rates within behavioral health that will help us to incentivize, hopefully, in our system and pay at the appropriate rates for different kinds of customers receiving

different kinds of services. That should help us right-size our system relative to, you know, as we talk about people getting the right care in the right place at the right time. And we're also undergoing a pretty big effort applying for a federal grant that would help us through that even more.

So part of our issues relative to integration have to do with our rates and our integrated system of care and how we look at services in the community sector versus the physicians' clinic sector versus the primary care sector.

I think -- I'm not sure that I said we are in our FY14 budget process in the Department of Health and Social Services, and of course, I think people realize that, when we're in process, we're not really at a point where we can talk about what's in process because we haven't gotten to the end of that, and we certainly aren't to the point of looking at the Governor's budget, but I would say that some of the issues being considered in the Governor's budget -- or for the Department of Health and Social Services are relevant to the conversations that we've been having. And that concludes my thoughts.

COMMISSIONER ERICKSON: Does anybody have any questions for Melissa? Yes, Keith?

COMMISSIONER CAMPBELL: We put a lot of emphasis on the medical manpower shortages in the state. I know your division and the whole feel has been pretty short of qualified workers.

Has that improved any in the last year-and-a-half/two years?

MS. STONE: I haven't seen a, you know, quantified record, so I couldn't tell you in terms of actual numbers. I'm trying to think anecdotally. I know that, relative to the detox issue, RNs have absolutely been a problem. Anecdotally, I can't think of any other situations that have come to my attention. We're certainly conscientious of that problem relative to this whole issue of, you know, where services are most appropriately provided and trying to figure out the right competency and educational requirements, so that we don't make the problem worse. But in answer to your question, Mr. Campbell, I don't know the change. I believe the workforce study is in process for -- the updated study is in process, but I'm not positive of that. Yes.

COMMISSIONER ERICKSON: Other questions for Melissa? Thanks very much for the status report, Melissa. I appreciate it. And next, Duane Mayes, the Director of the State Division of Senior and Disability Services is just going to give us a quick status report. For folks in the room who might have been with us all along and for our two newer members, we had made a decision, at some point, not to engage directly as a Commission in long-term care planning, but we're very interested in learning about the significance of long-term care services to the health care system and had an excellent presentation a little more than a year, year-and-a-half ago at

this point from a coalition of folks that included Mr. Mayes and the status of work to look at all of the long-term plans and reports that have been developed over the past several years and the status of implementation of various aspects of those, and we said would follow, over time, what they were doing. So this is more of a status report, not related to a direct recommendation.

MR. HAYES: Well, good morning. So you said a year-and-a-half. Actually, you know, it seems like a year-and-a-half. So much has happened, but I think it was October of 2011 the Commission came together. It was a meeting, and I and our contractor with Agnew and Beck, who helped facilitate some of the efforts that we put into developing a report that we presented to you back in October of 2011, I believe -- but in that report, we did a lot of number crunching in terms of long-term care support. So much of that report had to do with kind of where we're at in terms of the State-of-the-State with long-term care, how much we're expending, what will happen if we do nothing in terms of trying to change the system so that we can serve those that need long-term care services in the state. So kind of projected forward. So we had a lot of -- it was data rich. So we presented that. At the very end, we made a recommendation.

So this Long-Term Care Steering Committee consisted of about 18 people. We had multiple meetings prior to October to

kind of come up with that report and then present to you. And so our recommendation, at the end, was to really split the group into two, have really two different directions. I realize that, as the Director, long-term support services are huge. It's the elephant in the living room, and my responsibility, as a Director, is to the Division. And so the group agreed that we would split the group into two and we would have one group dealing with more of a global perspective of long-term care in the state and another group, headed by myself, to move forward with what could we do to address and improve efficiencies in terms of long-term care within the Division of Senior and Disability Services. So we did that.

So the internal group, which consists of, right now, internal staff with the Division, our leadership, the managers, the executive team, we put in countless hours of developing what we're referring to as the Division's Strategic Plan. And as you know, a lot of time goes into really developing a very effective plan.

I used -- I'm just going to refer to as the three-year plan, but it's a revolving plan in that there is also an attached work plan to it. And so, you know, we're addressing our action items from a monthly basis and moving forward, and every year, we come together as a group to try to identify what we have accomplished and what additional recommendations we would need to make. So it's a working plan.

We have probably put in hundreds and hundreds of hours into this. We have close to a final draft. A lot of work has gone into it. We've broken it down into really four areas.

One, of course, would be home and community-based services. That's, obviously, huge and so we have that as a section to the plan. Another piece would be quality assurances, you know, what can we do to make sure that the integrity and program is front and center. The third piece is that, within the Division of Senior and Disability Services, we have our Adult Protective Services Unit and that's huge for us. And so we created a category and some recommendations around trying to elevate and enhance our ability to protect vulnerable adults in the state. And the fourth is more of an administrative internal. What can do we internally in terms of creating some efficiencies?

So we have that draft, and it's not ready for the public yet. It still needs to be vetted through the Commission's office and that's where we're at right now. It's a 70-page document. It is what I refer to as data rich. We use the model -- and I learned about this model years ago, and the Department has embraced it -- called Results-Based Accountability, and I learned this model actually through Alaska Mental Health Trust years ago in a former capacity. And so it's a data rich plan. It's still in draft, but it looks pretty darn good. And so I'm hoping that we get the

green light to move forward from the Commission's office, but it needs to be vetted first through that office before we make it public. So that's the Strategic Plan.

Some things that have come from that though are the -- you probably have heard of the Community First Choice option and so one of the recommendations that I can speak to that came from that plan under HCBS is our CFC option, Community First Choice.

So going back in time to October of 2011, it was during that month that, through the Affordable Care Act, the Center for Medicare and Medicaid Services came out with a new option called 1915(k). The Medicare Task Force gave us the recommendation and the blessing to move forward in considering that option. And so in getting into the weeds, I'm not going to do that, other than tell you the big thing about 1915(k) is that you get an additional 6% federal match. So right now, we get about 50%, and with that additional 6%, maybe we could do more to serve Alaskans in this state. So that was the primary motivation, was to pursue that option because of that 6% match.

So that started in October, and one of the requirements is that we have to form and develop a council, a CFC council, consisting of stakeholders out there that actually receive services to include providers that provide the services. So we created that council, and as you know, you know, in that

effort, everybody wants to get on that council and have a voice, and I will tell you that was somewhat challenging because a lot of people were knocking on our door wanting to have representation, but we felt like we did a good job of making sure that that was balanced.

So in December of 2011, we came together and we created that council. We announced it and then we began to have our meetings in January.

The other thing is that we hired a contractor. Trying to do all that work internally, in addition to doing everything else that we do as a division, would be monumental, and we would be at it for years and years. So the Department made a decision to fund the hiring of a contractor.

So we hired a company out of Baltimore called HCBS, Home and Community Based Services Strategies, Inc. They have done some work in the state before on long-term care back in 2008, and I met the gentleman who owns the company. I was really impressed with him. So we put an RFP out, and he was awarded that contract.

And so it was a six-month contract. We really wanted to contain it because we didn't want to be at this forever and ever. So the contract started January 1 and went to the end of June of 2012. So we had multiple meetings to look at the -- - three more minutes -- CFC option, and in that journey when we got to May 7th of 2012, CMS scheduled a national

teleconference call to address CFC and said that they were going to make a change in that we could only pursue 1915(k) for those that need institutional level care. We wanted to use it to replace, as a possibility, our Personal Care Attendant program because that program is just exploding in terms of cost and growth. Well, that changed the ball game. So we had to step back and look at, what do we do now?

Well, there is another option called 1915(i) that we are looking at to address those individuals that do not meet institutional level of care. So within our PCA program, about 40% meet institutional level of care and 60% don't. So we have pulled back and we have revisited -- and I know my time is running out -- and we came up with a recommendation, through the Council, to the Department to consider reformatting and looking at these two options, including our waivers, and called it the Alaska Community Choice program, develop a council of ACC members, making sure we have representation throughout the state on that council and methodically moving forward to take a look at that.

So the contractor completed his report in June of 2012. We got that in July, so just a couple weeks ago, 150 pages long, multiple recommendations, one being the formation of the ACC, and we are, at this point in time, looking at it and reading through it and looking at the recommendations, again, at the Commissioner's office. So we're looking at that, and

a) we may move forward with the ACC, the new term, or b) we may not. But I will tell you it has been fast and furious for the last 12 months.

COMMISSIONER ERICKSON: Any questions for Duane? Well, thank you for that update, Duane.

MR. HAYES: You bet.

COMMISSIONER ERICKSON: Next on our agenda, we have Commissioner Bill Streur from the Department of Health and Social Services and Josh Applebee, also from the Department of Health and Social Services, who are going to update us on a couple of significant issues related to the Affordable Care Act, federal health care reform, State decisions related to the Health Insurance Exchange, and also since the Supreme Court decision earlier this summer, the role of the State in Medicaid expansion.

COMMISSIONER STREUR: Thank you all for this opportunity. A couple of observations before I begin. Just as Deb was introducing us, it flashes up on the screen (indiscernible - voice lowered). I hope that's not the message we end up delivering to you today.

Secondly, in talking about the Health Insurance Exchange and the Medicaid expansion, it's kind of nice to help you wind down from the day with these very noncontroversial subjects that are here.

What we'd like to do is give you a quick overview -- and

I'm going to let Josh cover the Insurance Exchange -- of the Insurance Exchange and then I'll do a little bit of a short recap on where we are with the Medicaid expansion, but then I'd like to open it up for discussion because I know there are some very interested folks who would like to weigh in, and if not give me a piece of their mind, at least give me their opinion on things. Right, Val?

MR. APPLEBEE: Good morning. I think it wasn't too long ago I was sitting here, looking at all the same faces, going, well, but we know a lot more know than we did when I came before you not too long ago. I assume that everyone knows that our contractor released our report on the Health Care Exchanges. It's on the website for the Department, if you care to look at it. There is a lot of good information there. I won't rehash all the data points from the report, but we also know that the State of Alaska will be moving forward with a federally-facilitated exchange, and the exact way that's going to get implemented is still up in the air, and I'll tell you why.

We're still waiting -- and I really hate to sound very repetitive from my last presentation, but we are still waiting for guidance and other information from the federal government of exactly how the federally-facilitated exchange is going to work, how the federal data hub is going to work, what it's going to cost, what we need to interface with it, just a lot

of unknowns, development costs, administrative burdens, interoperability issues, and just what it's going to mean for us here in Alaska.

To date, only 15 states in the District of Columbia have passed legislation to establish exchanges. Seven have specifically decided to go with a federally-facilitated exchange. Three have identified that they're going to go with some sort of federal state partnership and then everybody else, and they range from still looking at options to waiting until November to see what happens at the end of the election.

So it's safe to say that the federal government doesn't even know how many states they're going to be dealing with when it comes to a federal exchange. They estimate that as many as 30 states will be going with a federal exchange, but again, they don't know that because these decisions haven't been made, and most of these states are still on the fence. That should become very clear on the 16th of November. All states are required to submit to CMS their blueprint and make it known their official decision of what type of exchange they're going to move forward with, but as we all know, the 16th of November comes after the first Tuesday, so there could be a lot of scribbling in ten days.

In developing the federally-facilitated exchange, experts believe that the federal government should have no trouble actually establishing the website. In fact, when we were

looking at doing a state-based exchange, that was the easiest component. Setting up the website and having something that people can go to was probably the easiest component. When you start talking about Medicaid eligibility, when you start talking about determining what plans are going to be qualified, essential health benefit packages, all those other components, that's really where the difficulty is going to be.

So I arrived at the office very early this morning, and I came up with three terms for you. Soon, HHS will release the federally-facilitated exchange implementation schedule to the State. So the State is going to align their work, and they will release additional guidance on how they will implement the partnership arrangements with the State. I have it bolded, soon.

HHS plans to go through a rule-making process for the essential health benefits. They put out a draft. They received some comments, and they're looking to come together with a final rule. That, they expect to have out shortly. They're also in the process of formulating the guidance for more detail on the operational aspects of the federally-facilitated exchange. Those are going to be issued later this summer.

So I have soon, shortly, and later this summer, but it is important that we're still very much focused on making sure that whatever guidance comes out, our focus is going to be on

how to best fit that for Alaska. So the more details that we get the more descriptive our analysis will be and the more answers I can provide. So any questions about the exchange process? Yeah?

COMMISSIONER CAMPBELL: Yes. Exchanges, I guess, are going to be a moving target. Do you know how many customers potentially are in Alaska or does that depend on the decisions on the expansion of Medicaid?

MR. APPLEBEE: That will depend on the expansion of Medicaid. Our consultants, in their report, went based off of the full implementation of the Affordable Care Act, and their estimate was about 77,000 people to use the exchange in year one.

COMMISSIONER MORGAN: I was looking at the literature out of Massachusetts and New York, who have already gone through internally in their states of having exchanges, and looking at information on -- which there is -- like you said, everyone is kind of waiting, but what I can't seem to find out an answer to is, especially in the situation of New York State that's had an exchange for a while, just like Massachusetts -- being a southerner, it's just hard for me to say Massachusetts sometimes. Exchanges are supposed to become -- this is a philosophical question, so you don't have to write it down, if you don't want to. Exchanges are supposed to become self-sustaining after so many years. Yeah, 2015. If they're not,

is whoever is in charge of the exchange responsible for the shortfalls that would come out of the exchange?

MR. APPLEBEE: Yes.

COMMISSIONER MORGAN: You're the first person -- and I talked to Senator Murkowski's office, Senator -- I've asked three federal -- or a national delegation to Congress that. No one -- you're the first person. So you are now the resident expert on this, I guess.

The other question was, when I was looking at the -- I'm probably the only -- as you can tell, I have really no life outside of gardening. When I was looking at the actuarial report, a lot of their projections were based on, basically, standard, regressive, or linear analysis, but when I looked at New York that's had (indiscernible - voice lowered) in exchange, and granted, New York's exchange is not -- it has some -- is not exactly like this, but Massachusetts' exchange is very much like this, what's being proposed. What struck me by it was -- and I'm not criticizing the report. I've done reports like that. Sometimes you just have to do the old, you know, MBA stat course projections, but their experiences were, since we have two pretty good laboratories, that it wasn't linear, that adverse selection happened, that the set up of the pool had a lot more usage, and adverse selection brought higher utilization, especially in the first two or three years. Then it kind of settled down. And the increase in

cost of the premiums of allocating the mandates, which everybody loves -- several times, I would get in heated discussions saying, hey, to keep your kids on insurance and all the other things we all like, several states, through their commissioner or their board, like this, of insurance, can do it; 17 states did as far back as 20 years. The problem was -- which they accepted -- this is how much it was going to cost in everyone's premium, but you know, there is no free, right?

So I would ask you guys -- and I'm sure you already are -- when you do review the analysis and work through this, that you look at New York and Massachuset's stats. Don't look at the philosophy. Don't look at the feel good parts, but actually look at the hard numbers. They're there, and bring that into your computation of any exchange because things don't -- we find that you can linearly project things, but life isn't linear sometimes. And that's not saying anyone is bad or anybody is good. It just means it's mathematics, like any cost study. And maybe, when you look at them, you'll say, well, you know, it kind of doesn't apply to us, but when I start flipping through their reports from their state, you know, they report it yearly on this. New York is still, after seven or eight years, having to cough up money to help fund their insurance exchange. So whatever it is, we need to know what it is from a budget standpoint, I would think. Whatever

that is worth, John [sic]. I don't -- you know -- so.....

MR. APPLEBEE: Well, thank you, and I think those comments are spot-on because New York and Massachusetts are still developing their exchange to fit within the Affordable Care Act. So the exchanges that they developed are not Affordable Care Act approved. So I think they're learning from their mistakes, and we should, too.

COMMISSIONER DAVIS: Josh, thanks for your comments. So we discussed earlier occasions. There are kind of two pieces to the exchange. There is the mechanics that you talked about earlier and then there is all the policy decisions that need to be made. What's your thinking, in a federally-facilitated exchange, how much of a role does the State continue to be able to play on those policy decisions? For example, the rules around what carriers get to participate, what kind of accreditation is required, rate review, does it continue to be state or does it move to federal, those sorts of issues I'm very interested in your thinking about that, please, if you can.

MR. APPLEBEE: Well, I think it's going to be incredibly critical that we maintain our current level of participation in the regulatory process, specifically in terms of rate review and everything else. And so fighting for that and making sure that that doesn't go away is one of the things that we're very keenly focused on.

Because of the unknowns, there are kind of wide speculations between, well, the federal government is going to come in and take it all over to there is no way the federal government can handle 30 plates spinning in the air, so they're going to rely heavily on the states to do whatever they can to make sure that they have a successful product come January 1, 2014.

So from our perspective -- and I just had several meetings with our new Division of Insurance Director, Bret Kolb, and he's very much committed to making sure that the State maintains as much control over those processes as possible.

COMMISSIONER DAVIS: Good. Thank you. I'm glad to hear that. We've shared with Commissioner Streur, on previous occasions, and with Director Hall when she was in that role the numerous policy decisions that need to be made, and I feel very strongly, as an Alaskan, that whatever we can keep here on the policy realm we should. And fine; let them create the infrastructure and the way that it works, but we need to be able to make those decisions in a way that works and continues to have a -- create a sustainable market in Alaska. So thank you for your comments.

COMMISSIONER DAVIDSON: So I think you mentioned three terms, which were soon, it sounded like very soon, and imminent. I can't remember what those were, but it sounds

like there is one more, which is an Alaska term, which is after all that. And I think that -- but at the same time, you have to have a decision by mid-November, and so on the one hand, you have to wait for a little bit more guidance from the federal government, but you still have that mid-November deadline. So what, really, are the internal deadlines of the Department to make sure that you have what you need to be able to make a decision by November, mid-November?

MR. APPLEBEE: Well, certainly, we'd like to have as much information as soon as we can have it, but the decision to go with the federally-facilitated exchange has already been made. So at this point, it's a matter of working within the environment that they create to make sure that we don't, as Jeff pointed out, give up these regulatory processes that we need to maintain our insurance market in the state, but also to make sure that -- once they've decided how it's going to look and how we're going to interface with it, then we'll make those changes to whatever it is in our system, whether it be our new eligibility information system, whether it be any sort of project that is in the works right now, to make sure that it interfaces with what they're putting out, so that we're not left out in the cold. And so I think -- I don't know. I don't have specific deadlines as far as when we need to have everything because I don't know when we're going to get -- and we're kind of -- and every state is kind of in this bucket

where we just don't know when they're going to come out with the information that we need to move forward, but -- and certainly, every chance that I've had -- if they -- I've asked CMS, and have made sure that they're very clear, that, if they're requiring the states to make their decisions by the 16th of November, they need to make sure that the states have the information to make that decision before the 15th of November, with any hope. And so I think they're doing an impossible job. They're trying to get as much done in a timeline that's almost unachievable, and I think they're doing a really good job. It's just a matter of getting out their final product and letting us know some final decisions.

COMMISSIONER ERICKSON: Josh, I know Linda Hall had been really actively involved with NAIC, the National Association of Insurance Commissioners, and that's a body that's been -- done a lot of work in support of the federal government's work to lay out some of the standards and guidelines and to help with regulations and those sorts of things, and I saw that they just very recently created a new workgroup to work specifically on recommendations for the federal government related to the federally-operated exchanges. Do you know if Mr. Kolb, Linda's replacement, is on that workgroup or not? I was just curious about that.

MR. APPLEBEE: I don't know if he is on that workgroup. We were just at a conference for the NAIC. I was there for

the exchange part of it. We attended it together, and I think that Director Kolb is jumping in with both feet. I think he's really gearing up to make sure that he understands where Alaska is now and that we want to keep Alaska there in terms of that.

But the NAIC, they run a program that does rate filings, and it's a way for state governments to interface with insurance companies. It's a program called SERFF, and SERFF has been very much in front in maintaining their position that whatever the federal government comes out with, whether it be a federal-state partnership, state-based exchange, or a federally-facilitated exchange, they want to make sure that states still had the ability to approve rates, approve filings, and keep that communication with insurance companies exactly the way it is and then sort of add this new component. So I think they've done a really good job being on the forefront of that, and I think Director Kolb is going to keep on top of that.

COMMISSIONER ENNIS: Josh, you mentioned that you're a little bit concerned that the federal government will have 30 plates to juggle and that the State of Alaska will still have a lot of work to do, and then thirdly, that there is so much information that we don't yet know about what we will, as a state, need to do and what we won't be able to do. Could you provide the basis for the decision that's been made already to

go with a federally-facilitated exchange? Thank you.

MR. APPLEBEE: Well, I think the basis for the decision largely centered around cost. In our consultants' report, in their estimate -- and again, as Mr. Morgan pointed out, sometimes their analysis is very linear, but in their estimates, the state-based exchange came with an annual operating cost of about $7 million, in addition to all the development costs. We're just talking annual costs. And in his press release, the Governor made very clear that it was his belief that federally-mandated programs should be paid for by the federal government. And so I think that was the basis of his decision.

COMMISSIONER ERICKSON: Any other questions for Josh about the Insurance Exchange? Yes, David?

COMMISSIONER MORGAN: But after 15, if the Exchange runs a deficit, then whoever is running the Exchange is responsible for the deficit, and I think we all could agree that even -- that's a risk that probably, I would think, would be weighed and that would be on top of operations after 15. Now it could go the other way, but when you start looking at New York and Massachusetts, who did not have as stringent with so many -- with so much stuff going on inside the exchange of allocation, you know, the 40% from the gold to the bronze to the whatever, that that may be the minimum after 15, the operating costs, that there could be costs after the 15, to handle any

deficits, if there are any deficits. Or is that -- have I got it wrong? And that's possible I got it wrong.

MR. APPLEBEE: We asked our consultants to be as objective as possible, and we didn't go down the road of "what if" scenarios, like you're talking about, but certainly, if one wanted to look at the worst-case scenario, it's definitely out there.

COMMISSIONER ERICKSON: Commissioner? The Medicaid expansion.

COMMISSIONER STREUR: Before we go into that, I want to talk just a little bit about the Exchange and where we're at because David brings up a good point, a touchdown good point.

One of the big issues that I'm concerned about with the State doing its own exchange is cost. The second one I'm concerned about is our ability to implement the requirements of the Exchange. Jeff knows this, as well as I do. With our finite population of insured souls, to put in a bronze, silver, gold, and platinum plan and make the actuarial numbers work is nigh on to impossible, if not impossible. Also there is going to be -- there is a requirement to bring in a national component to it, a national health plan component to it, and what does that look like, and who is going to want to come up here with four levels of plans, selling insurance in Alaska under Alaska insurance regulations for such a finite number of people? And it goes on and on because you start

peeling that onion back. It's much more complex than just the setting up an exchange and selling it, but the cost is significant. What was estimated -- in the early days, the cost of the exchanges for states was going to be between $5 and $20 million. The reality is I haven't seen one under $20 million, and I've seen one as high as $136-$137 million. If we spent $20 million on exchange and then operating -- $7 million a year -- we have 700,000 souls in the state. Do the math. And that's got to be paid for in some way.

A little bit tongue-in-cheek comment, when you're talking about who is going to be on the -- is the operator going to be responsible for any losses? And you know, I was thinking maybe we could go to ASTHMA, ASHNHA, or ANTHC to become the operator of that, and the State could stand back and watch. No. Seriously. It is.....

COMMISSIONER CAMPBELL: (Indiscernible - away from mic)

COMMISSIONER STREUR: Medicaid expansion. I know there are people in this room, I know there are people statewide that say just hurry up and make a decision. You're not going to see a hurry up on making a decision. We've got to work the numbers. I am going to maintain, and have maintained and am going to maintain, that we don't even know what the population looks like. I need to understand the scope. I need to understand the population a whole lot better than we do. The estimates of the possible covered population on a Medicaid

expansion actually go from 30,000 to 60,000. A few came out and said we have 60,000 lives that are eligible for the Medicaid expansion. That was the highest one. Kaiser came out at upper 40s -- I mean, sorry, upper 30s. We had an estimate of 35,000 and then I've seen a low one coming out of HMA of about 32,000. So there is your scope, 32,000 to 60,000.

The other part is, what do they look like? One report that came out of one of our IHS facilities is that 50% are Native, are going to be Native. I can't make those numbers work in any way. So we've got to figure out how much of that is going to translate to Alaska Natives, American Indians because that has a direct effect on the costs both to us and the tribal facilities.

An important consideration as well is, do we have the capacity? And to understand whether we have the capacity, we have to know what the population looks like; we have to understand what their needs are. How many of our military are going to become eligible under this? We're seeing an increasing number of young military families enrolling in Medicaid, and you know, what is the effect going to be in terms of our relationship with JBER and other facilities?

It's not as simple as us saying, you know, we're going to cover a whole bunch more people, and it's going to help the world. We have to get those numbers, and I have to put a

recommendation in front of the Governor that I feel good about. So we're going to do an actuarial study. I know -- I hate studies, believe me, but I have to do it in this case because we have to understand it. We have to deal with the concern that some folks have that the Affordable Care Act is adding bodies to a system that's already broken. We have to understand our capacity. We really need to know whether our tribal partners have the capacity to take it on, as well as our non-tribal partners. Do we have enough physicians? Do we have enough practitioners? Do we have enough community health aides? Do we have enough? And are able to sustain it? What's that population going to look like? What's the cost going to be? The cost -- right now, just looking at our 35,000 numbers, our state first year costs are going to be at about $11 million. You say, what do you mean, $11 million, the Feds are going to pay 100%? They're going to pay 100% of the cost of care. They're not going to pay for processing the claims, enrolling the people, paying the bills, and doing everything else that's attached to that, so that -- I mean, if you look at 35,000, that's a 30% growth in the covered population. I can't do it with the existing people that I have. I can't do it with technology. So there is a cost there. The federal share on that would be about $340 million. So you know, that would be a lot of money, potentially, coming into the state, based on that 35,000 lives as we understand

them today.

What level of plan should we have? Should it be the current Medicaid plan where, you know, first dollar coverage for just about anything that they need or want or should it be more like a CAMA (ph), just a very, very base catastrophic plan? And so part of the actuarial study is going to be to get me those numbers once we have some population.

So with that, I'll stop on where we are, but right now, the decision is pending and will stay that way until we can feel good about it.

COMMISSIONER ERICKSON: Questions for the Commissioner? Keith?

COMMISSIONER CAMPBELL: I could anticipate quite a few unintended consequences that you haven't mentioned. Would you care to throw out some more or have you identified all of them you think that might happen to us?

COMMISSIONER STREUR: That was a short list. There are continuing concerns. My big ones are capacity and cost.

COMMISSIONER CAMPBELL: Well, I was thinking about the institutions. My thoughts keep drifting back there, in particular in our small rural place. It's a critical access hospital. It's been getting disproportionate share payments, but those go away, as I read this, if this intended capacity and coverage, as a tradeoff -- if the new patients aren't there and if the disproportionate share of money goes away,

that puts all of these small rural hospitals really in jeopardy, at least as little as I know about the formulas. And I just wonder -- because that was a federal tradeoff -- the increased insurance coverage and patients under Medicaid, et cetera, and the insurance people being covered through your exchanges would the tradeoff for these dollars going away for a disproportionate share. So I guess we ought to think about those kinds of things because, under the Act, that tradeoff has already happened, and if it doesn't happen -- if the increased capacity or paid patients aren't there through some mechanism, then these small places are in dire straits.

COMMISSIONER STREUR: First of all, rural hospitals are probably going to be less effective with the DSH, the disproportionate share hospital funding, than you think because the majority of them don't track uncompensated care to the level and to the detail and so really don't tap into the DSH funds all that much. But it still raises a good point, how much DSH is going to be there going forward? I can't get that number and that's one of the things that's downstream. You know, the federal grant funding as well is another one. What's that going to mean to our behavioral health system? If we implement a Medicaid expansion, is the grant funding going to go away, or if we don't implement the expansion, is the grant funding going to go away? Because something has got to pay for it.

So there are so many moving parts that the standard reply is shortly, soon, or later this summer that we're getting the same responses on. It's the same meetings, the same people, so it's well-rehearsed answers.

COMMISSIONER ERICKSON: Dr. Stinson?

COMMISSIONER STINSON: When they were talking about the Law of Unintended Consequences, one of the things I've seen in my practice for a while is that there are a lot of people who move up to Alaska for Medicaid coverage, and previously, it's because they had family or some other relationship to Alaska in the past or maybe ongoing and family members would bring them up and that's fine. You know, I want everyone to get good coverage because we want to provide good care.

Lately, I've been seeing a lot more people who are just moving up to Alaska for Medicaid. No ties to the state. In the last week, we've probably had three or four in our clinic from Michigan, Oregon, states -- and they'll be honest about it. They said, they're cutting their benefits so much, we got online and here we are.

And so on one hand, you want to provide good coverage for the Medicaid population, but if you make it real good, like you said the platinum, you might have a lot more than 35,000 people signing up for Medicaid in Alaska, and these are some of the other things that people don't immediately think about it, but I'm seeing.

COMMISSIONER ERICKSON: Other questions for the Commissioner? David? And Val, did you -- David and then Val?

COMMISSIONER MORGAN: Again -- and I'm not saying anything that I'm sure you're already doing, but just I have to say it. Don't use just linear. Take in the market forces and look at Massachusetts and New York, even though they're not identical in insurance exchanges and their Medicaid activities during that transition. But adverse selection -- more people -- you know, that estimate may be low. The PEW study might be closer, depending. And do it -- you know, at least have a second page that says, well, we think -- this consultant says this, but looking at Massachusetts, looking at New York, who have done this already, this is what could happen. And Massachusetts' experience going through their process, it got to the point that they had to reduce benefits in order to keep the system from crashing, even with a major infusion of Medicaid money from the federal government.

So it's sort of like when I used to be a Commissioner of Boy Scouts. Everybody really wanted to get back to camp for those hamburgers and hotdogs, all those goodies, but they keep forgetting that we still had to put all the canoes away and fill out the paperwork and take our water safety course and go through that process. So I'm not -- I know I'm not saying anything you already don't know. I just -- I feel so much better now. It's more therapy for me that -- and I know I get

down into the finance too much sometimes, but these are big decisions. And as I said earlier -- I don't know if you were here -- there are choices that are great that are cost-effective and are even better medicine by our physicians, but the pie is a certain size, and if you suddenly have to start writing checks for $7, $10, $20 million, that's got to come from someplace. And we all have -- and we all know that, and we all know we've got to operate into that situation. But it's really hard to make decisions when you have a blank sheet of paper; I know that, too. So good luck. You're going to really earn that Commissioner title, I think, over the next year, and I wouldn't have it for a million bucks.

COMMISSIONER STREUR: Salary, too?

COMMISSIONER ERICKSON: Val?

COMMISSIONER DAVIDSON: So thank you so much for the information. You mentioned a couple of times the capacity, and you mentioned the tribal health system. And for some folks in the room who may not know the relationship between the 100% FMAP and the impact on sustainability, it's a very real one. I'm glad you brought it up. The 100% FMAP for the first few years of Medicaid expansion is not going to last forever.

One of the things that you're considering is sustainability, but for IHS beneficiaries who are also Medicaid beneficiaries who receive their care in an IHS

facility, that's 100% FMAP and so that does impact the long-term sustainability of the program. So folks who are on the phone who may not know that and folks who may be in the room who may not know that may have wondered why you brought that issue up. So one, it's just a point of sort of broader education for folks.

But I do want to let you know that I am -- I, and many others in the tribal system, really appreciate the care and the thoughtfulness and that you are taking the time to do the actuarial analysis, to be able to really dig deep to find out how many people really are we talking about, what kind of care do we think they are going to need, where do we think they're going to receive that care, so that, really, the State can make a very informed decision. And I guess I don't really have a question, but I do want to say that we really appreciate your taking the time to be able to do that thoughtful analysis before a decision is being made. So thank you.

COMMISSIONER ERICKSON: Yes, Emily?

COMMISSIONER ENNIS: I have a question for the Commissioner. Prior to the Supreme Court's decision, this Commission really had sort of a hands-off status in terms of the Affordable Care Act. At this point in time with all the work before you and the information to sort through and the new data to gain and a lot of decisions to make, do you see a

role for the Commission in the process to assist you?

COMMISSIONER STREUR: That's a hard question right now, and I say it's a hard question because, well, first of all, Deb and I talked about it yesterday, and I couldn't answer it then either. I don't know what's going to come out of this thing. And short of the actuarial analysis, I don't have a plan beyond that. And you know, that's a hard thing to say, but until I know, you know, what the in is, what it is we're looking at, what the population is, I almost have to have that before I can get in the car and make the drive, in other words, put the plan together. And right now, what we're doing -- what I'm doing is trying to pencil out first steps.

A role for the Commission going forward? Being supportive. Helping us with the tough questions. Having a discussion, like this, with us. Talk through some of the concerns that we have. Addressing the capacity. Right now, I do not believe the actuarial study will include a capacity study. We have big, big boulders with that in terms of the plan going forward. What is the capacity going to be?

When I look at Medicaid services to IHS beneficiaries, about 29%, this last year, were delivered in IHS facilities. So that means 29% of the folks -- or excuse me, 71% of the folks receiving care went outside the IHS system, and they got the 50% reimbursement. Is that number going to go up outside the facilities, if we do a Medicaid expansion? That's going

to change radically, the numbers in 2019 and beyond. So it's -- but as well outside. You know, Ketchikan. You know, you could potentially go, I believe, by a 3,200 total covered lives eligible to receive services in your hospital. Do you have the capacity? I doubt it. And Dr. Stinson, in your practice, the same thing. Dr. Urata. It's where is the breaking point and identifying that breaking, and I think that's a big amount of assistance that could be provided through this Commission.

COMMISSIONER ERICKSON: Keith? And then let's wrap up and take a break.

COMMISSIONER CAMPBELL: Oh, okay. Again, thank you, and I can -- I think I can feel a portion of the pressure you must have been under to make a precipitous decision to accept the federal role right away because we know the pressure we are under sometimes here about everybody wanting a seat at the table, and they can look at the expansion of their -- getting paid for things that they may not be getting paid for now. So I really appreciate the pressure you must be under, and I just want to say thanks for that.

I guess that it's not a question, but I just -- the big carrot coming down everybody wants to grab a piece of it, and sometimes, you don't think about those unintended consequences that -- I try to sometimes think about, but never get it right. So I hope you get it right.

COMMISSIONER ERICKSON: On that note, Commissioner, if we could invite you back to our October and December meetings, so we could continue this dialogue, would that be.....

COMMISSIONER STREUR: Happy to do so. And just to the point of asking the tough questions, a few of you have worked with me. You know that I love it. It's the way I operate, and we're not going to get the answers unless we have the questions. And the tougher the question the better chance we have to move things forward. So thank you.

COMMISSIONER ERICKSON: Thank you. We are about 20 minutes behind schedule right now, but I think we can make that up at the end of our morning session. So thanks again, Josh and Commissioner Streur. Let's take a ten-minute break. Try to be back in ten minutes at 10:30, and we'll continue with our next presentation.

10:20

(Off record)

(On record)

10:33

CHAIR HURLBURT: Let's get started again, please.

COMMISSIONER ERICKSON: If the Commission members could come back to the tables, please, and our speakers? I was going to -- make sure that you hit the silver button, and then turn it off when you're not speaking, and keep your mouth as close the mic as possible, that would be good. Thanks.

MS. LEWIS: So can you hear me okay or closer?

COMMISSIONER ERICKSON: Closer would be good.

MS. LEWIS: Is that better?

COMMISSIONER ERICKSON: It depends on if you're going to speak that softly or not. I just had feedback from some folks who have been on the phone that some of us don't hold the mic close enough to our mouth and don't speak loudly enough and so we're being mindful of the folks who are on the phone, who are listening through the sound system.

MS. LEWIS: Well, you can give me the.....

CHAIR HURLBURT: We've had the custom and the practice in our country of, for every decade, developing some goals and areas of focus related to health, related to keeping people healthy, keeping them living, and those are every decade. So we're now on the process of working toward our Healthy Americans for 2020 and Healthy Alaskans. Most states have had their own component that matches or works with the national component.

One of the things that the Centers for Disease Control has wanted to ensure this year is that this is not just something that state government does, but that it's collaborative with the community-at-large as well as state government there.

And so Jill Lewis, who is the Deputy Director for the Division of Public Health in Juneau, and Bev Wooley, who

formerly was DPH Director and now is with ANTHC as Community Health Systems Performance Improvement Director, have been partnering on this and working together. Bev happens to be with ANTHC, but Bev really is representing the community-at-large. Bev and Jill have worked on some of the specifics they'll be talking about, but also bringing together some advisory groups, again, with Roald Helgesen and Jay Butler from ANTHC and the Commissioner and me from the Department here, but again Roald and Jay are representing the community-at-large, not specifically just the tribal health system.

So that's the approach that we're taking. I'll turn it over to -- I think, Jill, you're going to go first, are you? I'll turn it over to you.

MS. LEWIS: Actually, I believe Beverly is going to go first.

MS. WOOLEY: That's fine. Thank you, Ward. I appreciate that. What we're going to do today is walk you through and talk a little bit about the National Public Health Improvement Initiative, which is some of the funding that we are using to keep our collaboration going, talk about cross jurisdictional collaboration, some health planning and assessment that's going on mainly around Healthy Alaskans 2020, and then just talk with you about some of the future plans that we have.

So we'll start out with the National Public Health Improvement Initiative, which is provided funding through a

cooperative agreement through CDC, and it's using the Prevention in Public Health funds of the Affordable Care Act, and the intent is to support state, tribal, territorial, and local health departments to improve their infrastructure and be able to provide better services. And I don't know about the rest of you, but I've been 30 years in public health and health in Alaska, and this is the first time I've seen a grant of this magnitude that really is working to try to break down silos and get us to work together to increase efficiencies across systems. So it's been very exciting.

In Alaska, funding was provided to three different sites, the State of Alaska Department of Health and Human Services, and then two tribal organizations, one being the Alaska Native Tribal Health Consortium and the other being SouthEast Alaska Regional Health Corporation.

We're currently wrapping up our second year of funding, and the first year was at $100,000. This year has been $250,000 at each of the sites, and we're expecting that that will continue at that level for years three, four, and five.

The focus of the initiative, as I said, is really on quality improvement and trying to increase effectiveness and efficiency for those critical services that not only millions of Americans, but literally thousands of Alaskans depend on every day, but both at that agency level, looking at agencies, but also moving out into the systems level. And when I talk

about systems, just to make sure we're all on the same, you know, page here, I'm not even just talking about what we sometimes think is health systems being, you know, the clinical care and the public health care, but this is really the entire community system because so much of what we see in health today relies not just on health care, but it has to do with education. It has to do with labor. It has to do with what's happening in small and large businesses, police enforcement. It's really across the board. So when we're talking public health systems, I want you just to really think that very large expansive system that's out there.

And in order to keep this effort going, CDC has required that each of the agencies, at a minimum, hire what they call a Performance Improvement Manager to keep the system going and for us to just get up every day and think about what we need to do.

At the State, Jill fulfilled that role up until very recently, and now that is being fulfilled by Lisa Aquino, who is in the back here. At the tribal system, I fulfilled that role, and again, will be bringing on another person to assist in this next year as we move forward. And we also have, I'll point out, Romey (ph) Michalski, who is here today, who serves as one of our co-chairs on the data team.

The overall system is to -- with NPHII, the focus is to increase, as I say, the public health system with the ability

to improve health outcomes for all people, and they do that and have focused us on three primary areas. One is just using data for evaluation and being able to guide us in setting up our programs to make sure that we can increase program efficiency, then promoting the increase of evidence-based programs and policies so that we aren't going out and just trying things and hoping it works, but we're actually looking to see whether a difference has been made -- and that is, often times, a challenge with public health because so many of our things we see the change ten or 15 years later, but we're learning to do this better and better -- and then also assisting health departments to meet national performance standards and accreditation standards, beginning with carrying out some of the core public health functions of doing community or statewide health assessments and health improvement planning, again both of which are being focused at that system's level and not simply at the agency level.

So to increase the impact of really rather limited funding, NPHII has encouraged the cross jurisdictional collaboration to work outside of the silos and the boxes that sometimes we find ourselves in and to leverage resources to increase efficiencies and effectiveness and also just to maximize efforts around health reform activities, so again working collectively, and to work at the system's levels across jurisdictions is also designed, by design, to increase

capacity in the delivery of services as we understand each other better and we can decrease those efficiencies.

I probably don't have to tell most of you here -- you come from different areas -- trying to collaborate and work across different jurisdictions is actually harder, not easier, in many ways. And so you know, we had to ask ourselves, why do we even want to bother doing this? I can just come in everyday, do my thing, and not worry about anybody else, but the reality is that we know that, certainly locally, as many Alaskans continue to have economic hardships, we're seeing increases for services. We heard someone, earlier, talk about people who are even moving up here to get services. So we have an increased demand at a time when we have fiscal constraints and many of our dollars are actually shrinking. And at the same time that we have all of that going on, rightfully so, I think, we have funders and policymakers who are really holding our feet to the fire and saying we don't want to just see more services out there. We want to see more outcomes. We want to see more results. You must be more accountable for what you're doing.

Working alone and continuing to work in our silos, we just will not have the capacity, either financially or with human resources, to meet that increased demand, staying within the fiscal constraints that we currently have. So we have to look at, what do we do now? Do we scale back programs? Well,

at a time of increased need, that's pretty challenging to do. The public doesn't take it well. It's challenging politically. So do we go find more money? If so, what do we do to find that? Do we raise fees? That's usually not very acceptable. I don't have to tell most around here that raising taxes is a big no-no. That just isn't going to make it.

So about the only that we have left to do is to work together. We can't continue to try to do more with less. I think that's been the mantra since I first entered professional life, you know, 30 years ago. And so in order to do that, we've really got to come together and work collaboratively and try to bring the best efforts in increasing what we're doing in our work together.

We know that we can -- when we have the right hand working with the left hand and knowing what we're going, we can actually begin to break down silos that we're functioning within. We can more easily identify the gaps in services, the duplication in effort, and actually begin to align what we're doing to make it more seamless, so that we're working collaboratively together and being more efficient.

It can also -- and this group might appreciate this because we have a limited group of those, if you will, that are the policymakers, and we also find that we are putting together another coalition, another task force, another

workgroup, and the same folks keep being asked over and over again. So if we come together and work more collectively, we're hoping that we'll be able to reduce that and actually have some advisory committees and coalitions that can work across the system in a more unified approach to providing the services that we need.

And with that working together, you end up having a shared idea, plans, and you share your data and your information more freely, just as you have been doing here today, and I think that's one of the things with the Commission that I know that works so well. When we do that, we end up with more robust information, better intelligence, and when we have that, we really have the potential to make much better policy decisions, service decisions, and certainly provision of services with the end outcome being better and healthier Alaskans throughout.

But successful collaborations don't happen in a vacuum. It's something that has to be worked at, and what we realized, as Jill and I started working with this last year, is the first thing we needed to do was to build on identifying those areas where we already have common purpose and common goals. And as you can see here -- and you've probably seen some of this before -- the State of Alaska, one of their goals is to protect and promote the health of Alaskans. At ANTHC, we are there to make Alaska Natives the healthiest people in the

world. Pretty similar there. And at the core of both of those, we really want to improve the overall health outcomes. We're both statewide organizations. We're both charged to provide public health services to our clientele, and not surprisingly, we both have similar health issues and concerns with our populations.

So as we looked around, it just made sense that we began to bring our efforts together. And I think, kind of more importantly, I always like to talk with my colleagues Outside. There is a lot of national work that goes on with this effort, and we find that, in Alaska -- and I'm proud to say this when I take it forward -- we are unique when it comes to tribal and non-tribal relationships, I believe, because we really do work and play and live together, but we also get our health care from the same providers, often times.

In rural Alaska, sometimes the tribal system is the only system of care. I know that my second born is a product of the tribal system, mostly. I actually delivered in Anchorage, but all of my prenatal care -- I was living in Barrow at the time -- was provided through IHS. I am not a tribal beneficiary, nor is my husband, but they were the ones that were in town. They provided that service. That happens throughout this state. We also know, as you talked about earlier, that, in other areas certainly, tribal members have the ability and take the opportunity to choose other

facilities outside of the tribal system to get care. So if we really want to have all Alaskans healthier, we need to blend those systems so that, seamlessly, we can provide that type of care. And additionally, we both -- both agencies have a charge, somewhere within either policies or guidelines, to work on health assessment and health care planning.

The State of Alaska, through statute, says that the Department may develop and adopt and implement a statewide health plan, based on recommendations of you, the Alaska Health Care Commission, and then at ANTHC, we've incorporated health assessment and health planning as part of our new strategic corporate plan, and we also think that it's very important to promote the health and wellness of our people through collaborative partnerships. So we do have a directive to move that way. And we know that we need to, again, work at that systems level so that we can begin to have that collective understandings. It's not what I think and what you think, but that we come together to fully understand both the current status, but also those needs so that, as we go forward to build the plan, we're not working across purposes, but we're coming together to actually align and bring about that coordination of services that we want.

And finally, how do we walk the talk? I'm very pleased to say that we walk the talk by co-sponsoring and co-steering the Healthy Alaskans 2020 initiative. It's very exciting. I

think this is probably one of the first times in the nation that we've actually had a tribal organization and a state come together to actually co-sponsor and take joint responsibility for moving this plan forward and doing the assessment together.

In fact, just two weeks ago, I guess it was, I was contacted by the American Public Health Association to provide a panel presentation regarding this collaborative work because this kind of thing just isn't happening other places. You might have the state who invites the tribes in to do something or the tribes who invite the state over to participate, but they typically have separate plans, and they haven't come together for this joint plan. So we're very excited that we'll be able to align our overall public health goals and efforts and that we will be able to push the curve in the direction that we're wanting to see that go.

So our intent, just to let you know, isn't to go out and just recreate the wheel. I know some people go, oh gosh, not another assessment, not another plan, but it really is to build on efforts that have gone on before us.

One of those, as Dr. Hurlburt mentioned, was Healthy Alaskans 2010. This is an every ten-year effort that we revise and update these plans. And so before we really launch into telling you some of the specifics about that, we want to give you just a real quick overview of, how did we do in

meetings those Healthy Alaskans 2010? Did we meet those targets, and where are we, and do we need to still keep working?

So with that, I'm going to turn it over to Jill, who is going to walk you very briefly through some of those and then outline what we're looking at with Healthy Alaskans 2020. Thank you.

MS. LEWIS: Thank you, Beverly. Good morning, everybody, and thank you for having us here today. I really appreciate the opportunity to talk to you about all the exciting work we're doing with Healthy Alaskans 2020. We think that we really have a good plan for a good process this time that is going to really create something that will be very meaningful to the state.

Before we get into Healthy Alaskans 2020, as Beverly said, we're going to take a minute and talk a little bit about Healthy Alaskans 2010, just very briefly.

Overall, we did about the same as they did nationally with Healthy People 2010. About a quarter of the targets were met, 42% saw a 10% improvement over the baseline, 47% of our targets made significant improvement, and about a third were neither improved or worsened.

We're going to look a little bit at the areas of concern, areas of promise, and areas of success. And on the next slide, we're just showing you a couple of select indicators.

There were over 400 for Healthy Alaskans 2010. So we're not going to look at all those. I know you appreciate that.

First, we're going to look at the areas of concern. These are where the target wasn't met and where we haven't really showed improvement. For the youth, you know, we've got physical inactivity and weight, suicide. For adults, you've got, again, the physical inactivity and weight and tobacco use.

Areas of promise where we had -- the target wasn't met, but we are showing improvement, we had a lot of areas there. We had, for youth, you know, violence and injury improved. Sexual risks improved. Tobacco, smoking, smokeless, and advice to quit that improved, and some of the screening improved. So those are some good signs, areas of promise where things have gotten a little better.

And there were lots of areas of success. For youth in particular, the tobacco and substance area saw a lot of success over the -- from 2010 and also violence and injury. And for adults, there have been some areas under some measures where physical activity has improved and some specific areas in the screening access. So that's sort of a nutshell, very brief overview of 2010.

And to talk a little bit about what we're doing now with Healthy Alaskans 2020, this is an update to previous health assessment efforts that we've done, and it's the building

block for some of the state health planning initiatives that are going on. The major goals, as you can see, are to improve quality of life, achieve health equity and focus on health disparities, promote healthy environments, a strong consideration of the social and economic factors that influence health outcomes, and to look at all ages and all parts of the lifespan.

To do this, we're going to engage a broad network of stakeholders and promote the shared accountability and ownership in contributing to the improved outcomes -- shared responsibility, so that it's not -- we don't want it to be seen as just something that was done by the State, which kind of is the view of what happened with Healthy Alaskans 2010 is that the State is responsible for it. We want that to really be a community thing this time.

Also for the indicators and targets, we want to focus our resources on a few key indicators instead of having so many. We did with Healthy Alaskans 2010. And we also want to set some realistic targets. Some of the targets that were set for 2010 were extremely ambitious and that's one reason why we didn't meet more of them. And we're going to be tracking the progress. With Healthy Alaskans 2010, we didn't necessarily assign anyone to track progress, and we have tracked some selected measures, but it was not done as systematically as we would like to see.

The process we have already begun in the planning phases, and the major work is going to be done between September of this year through September of 2013. And these are the main components of the Healthy Alaskans 2020. We'll have a statewide health assessment, choose leading health indicators, maybe 25 to 30 to monitor and watch. We will have Web-based tools. So instead of producing a book, which is what we did for 2010, we will have a Web-based interactive tool, and we will be using one of the State's tool, IBIS, which is the new interactive website for disseminating public health information, and we'll be using that as one of the key pieces of what gives us our Web-based tools. And we will be focusing on evidence-based strategies that are targeted at improvement, and we will have a lot of Web-based resources. They'll be available for grantees and community-based organizations to reference, so that they will be able to make use of and access all of these tools.

And we're not going to be rebuilding and starting from scratch. There is a tremendous amount of work that's already been done in these areas and so we will just -- we're pulling those things together so that they are centralized. They're a bit of a clearinghouse and a warehouse in a central location where people will be used to going and looking for these resources, so that we will build on the existing health plans that already are out there, existing indicators that are

already being collected rather than coming up with new ones for those kinds of things, so that we'll be building on that.

One of the key pieces of Healthy Alaskans is to reach out to the community. If the State and ANTHC just get together and do this thing, we certainly could, but it would be seen as something coming from the top down, and there really wouldn't be a lot of uptake in the community, and without their adoption of what recommendations come out of Healthy Alaskans, you're really not going to see that kind of change. You're not going to be able to bend the trend on those health outcomes.

So this is a diagram that we have that sort of shows how we're involving the community. The foundation is the Community of Interest. This is really involves anyone in the state who has any level of interest in Healthy Alaskans, and we're looking for a lot of diversity geographically, across race, gender, age, I mean, just all manner of diversity, and they will be providing input, through a series of surveys, on selecting our health priorities and selecting the indicators and the strategies that we want going forward.

We're also working with a data team, which I introduced Romey earlier. She is the co-chair of that, pulling together a lot of data resources, both from ANTHC and from the State. And then as needed, we'll have ad hoc subject matter teams so that, if we need substance abuse as a team and we need to

focus on that, we can bring subject matter experts together. Hopefully, that will help to reduce that stakeholder fatigue, where we invite the same people to everything all the time, and it also helps us in that we can limit membership then on the Advisory Team, so that the Advisory Team will be made up of about 25 to 30 people who represent a broad constituency. And for the most part, statewide, although there may be regional as well, these folks will be making the recommendations, ultimately, for what will be the leading health indicators and what will be the recommended evidence-based strategies that we'll be using.

And we're just now in the process of inviting the Advisory Team to participate and sending out invitations. The first kickoff meeting for the Advisory will be September 6th for a half-day meeting.

The Core Team is made up of members of ANTHC and the Department of Health and Social Services, so that we are really steering the project. We're the hands on, day-to-day support, doing all the heavy lifting behind the scenes and the planning.

The Steering Team. Dr. Hurlburt already introduced the Steering Team. It's the Commissioner Bill Streur, himself, Dr. Hurlburt, Roald Helgesen, and Dr. Jay Butler from ANTHC. And so that's the Steering Team.

And then advising us are our own agency Division

Liaisons, so that we get that rich contribution of information from all of these experts that we have that work on this kind of thing day-in and day-out.

You have this as a handout, I believe, in your book. It's not intended for you to be able to actually read all the tiny type on the screen. This is sort of a snapshot of the milestones of the project. We basically have four phases. We're in the planning phase now, and we're just wrapping that up. Then we're going into the next phase for defining the indicators and the targets, and during that phase, we'll be doing several surveys of the community of interest to get them to start first from a very large list of objectives and health care topics and narrow that down and give it some prioritization, which then the Advisory Team will look at and provide their recommendations to further reduce the number to, say, 50 or 60. And then we go through another round for more prioritization and input from the Community of Interest again. And eventually by about the spring of next year, we end up with the 25 leading health indicators. And then at that point, we start focusing on developing the list of evidence-based strategies that will be recommended to go along with those 25 leading health indicators.

We'll also be putting out a website with tools. The website will first go live next month, in September, and we'll continue to develop materials and resources as we go through

the project. The final report out, if you will, on the project will be in September of 2013. The report, itself, will be very small and just a recap of what the project is because the actual deliverable is the ongoing website tool that will be a resource for the future.

And then once we've gotten to that point, we really start, in 2014, going into, how do we implement these strategies, what's the plan, and how do we continue to engage the community and the stakeholders to actually use this information to form their grant applications, to decide what activities to pursue so that we maintain some focus on the activities, and therefore, hope to really make some changes in the health outcomes.

So after we get to the part where we have the website up and we've completed the first two phases, we have the implementation plan. We're going to focus on those leading health indicators with the shared topics and the evidence-based strategies. We really want to build on that statewide community participation that we had to form an ongoing coalition, if you will, to sort of refresh those people who have participated in the project to date. Some folks may want to, you know, continue to be involved. A lot of people will be ready, after a year of planning and activities, to move off of the committees. This is important, if we're going to maintain focus.

One of the things that happened with 2010 was, once they produced the books and the deliverables, everybody shook hands, patted each other on the back, and said what a good job they had done, and all went forth, you know, to do good things, but not together. And so the project lost focus, and because of that, we feel it didn't achieve as many objectives as it could have. And so we're hoping to learn from that and do a better job this time.

So you may recognize this slide. I think you may have seen this one once or twice. This is the Health Care Transformation Strategy for the Health Care Commission. And we think that the work that we are doing with ANTHC and the State of Alaska, with the Department of Health and Social Services, the National Public Health Improvement Grant, the Quality Improvement Efforts under that, the Healthy Alaskans 2020, all these things are consistent with the Health Care Commission's strategy for transforming health care.

Where the Health Care Commission has focused a lot of its time and energies looking at the clinical health, you know, Healthy Alaskans 2020 and the work that Beverly and I are doing together focuses more on the community health aspect, the public health aspect of the entire spectrum of health care in the whole system.

In looking at the slide that you guys have developed and talking about some of the value, access, health, some of the

highlights that are on the slide, under the value, I think that the Healthy Alaskans project, the collaboration that we're doing to leverage our purchasing power -- if you recall, the grant amounts that we receive are only $250,000 each. With that, we're supposed to hire people and transform the public health system. So we weren't going to get very far alone, so we joined forces because we can, at least, do more together and that's a key theme that we talk about often is how we can leverage what we're doing and what everyone is already doing in these areas and bring that together, and we really see that as the key role for that grant is not to go out and start something new, but to bring together all the work people already are doing everywhere. They're just not doing it collectively, in coordinated ways.

We also are, you know, making sure that we're being very data driven, that everything we're doing is evidence-based, and we have a lot of accountability in the tracking and assuring transparency of what is going on in the system by doing that kind of tracking and regular reporting.

Under access, the project addresses specific services and those evidence-based practices so that, you know, we can be sure that we're looking at what the priorities are in the different communities. In many ways, this isn't that much different from a community doing its own health assessments, except we're doing it for the whole state. So the community

engagement is a very important piece of that.

Obviously, prevention is going to be a key part of Healthy Alaskans and the work that we're doing with the National Public Health Improvement Initiative. We're looking across the lifespan, and you know, building in healthy lifestyles will be a key focus, we believe, in the areas that will be priorities. And hopefully, folks will be able to use the Healthy Alaskans 2020 output as some guidance for future policy change, sometimes from the ground up in what it is that we're giving grant money to and what activities are occurring at the local level, you know, to the highest levels to look at some of the performance measures and indicators and targets to see how well we'll doing with, you know, monies from the State or other efforts that are being put forward, and around statewide leadership, you know, the strong community commitment and support that's going to be necessary, not just to complete the Healthy Alaskans project by 2013, but the ongoing coalition to maintain focus, to maintain the energy and enthusiasm that folks have about the project today and that it doesn't all just sort of dwindle and disappear at the end. You know, measuring the improvement and strengthening the health data with the website and with the use of the IBS tool online, I think, are going to be some very dramatic changes that we'll be able to bring about from, at least, our current status.

So lastly, you know, we'd like to talk a little bit about how the Health Care Commission can participate in this effort, how, you know, your input is needed in order for us to be able to do and really achieve all of the things that we've set out as our objectives. So what we'd like to do is sort of just open up the floor and have a dialogue about how you see the Health Care Commission's input being helpful to us and ways that you might do that.

COMMISSIONER ERICKSON: Can I start off just by checking -- I don't want to make an assumption that everyone around the table fully understands what Healthy People and Healthy Alaskans plans and processes are, especially our newer folks. We talked about it, as a group, a couple years ago or so, but it's been a while. And so were you aware that, every ten years, CDC -- since 1990, CDC has come out with an assessment with some targets for the improvement of the health of the population for the country, and most states have modeled a state-based plan similar to that. And so we -- I can't recall if we had a Healthy Alaskans 1990. I don't think we did, but we did have Healthy Alaskans 2000 that was developed around 1990 and setting the targets for ten years from there, where we wanted to be in terms of the health of our population in ten years.

And then approximately ten years ago, this is Healthy Alaskans 2010, and as Jill and Bev referenced, in this

particular effort, there were 26 different focus areas and hundreds of different indicators across those different focus areas, primarily focused on different risk factors, like tobacco use and physical activity and nutrition and also certain health outcome areas, mental health, injury prevention, violence, abuse. So they gave some of those as examples, infectious disease, oral health, really vision and hearing health. It kind of cuts across the spectrum in a couple of areas that get at health care access and health care system issues as well. So I just wanted to make sure that just the basics of what we're talking about in terms of the process that we've got going and that ANTHC and the Department are collaborating on.

COMMISSIONER HARRELL: So a question and then follow-up comment. In terms of this report, you mentioned modeled after the CDC, is the CDC prescriptive in terms of this is your playground, you need to play within these areas to choose your items of interest?

MS. WOOLEY: No. In fact, CDC really encourages going out and doing these broad initiatives where you bring in as many players as you can to make sure it's meaningful to your area.

One of the things that even CDC learned from the previous, the 2010 version to the 2020, is that the only way to move it forward is if everybody is onboard together. And

so I think that we've seen that push even stronger this time than what we saw in the past, and they also have gone to narrowing down to some leading health indicators. There are many other indicators, and they're looking at those, but even at a national level, they've narrowed the leading health indicators that they're going to track and really post and promote all the time to 26, but they don't ever say that you need to do our same 26.

COMMISSIONER HARRELL: So then probably the last time I can use the newbie card, if -- (indiscernible - voice lowered) -- so to challenge the Commission in light of our topic from yesterday and today, if we move from a discussion of health care, which a lot of these preventative measures are actually driven towards in terms of quality indicators, to a discussion of health, we could then potentially include palliative care and the education and delivery of palliative care under the auspices of health for Alaskans and this avenue becomes one of the venues we could then use for the educational purposes that we've discussed, so that we can get to where we want to be, and the reason I think that is that you mentioned on your slide value. You mentioned on your slide design, policies to enhance the consumer role in health, which we've clearly talked about, access across -- or focus across the entire lifespan, ground-up initiatives, which Dr. Urata mentioned -- if we're going to do this as a Health Care Commission, then we

need to be focused on the community and moving upward -- and then commentary regarding community support in general, which palliative care absolutely focuses on. So I wanted to see what the rest of the Commission members think about that expansive definition and whether it actually can fit within this pre-existing project.

COMMISSIONER ERICKSON: (Indiscernible - away from mic)

COMMISSIONER MORGAN: Yeah -- it wasn't on this, if you want to continue this. I just had two, very short questions.

(Pause)

COMMISSIONER URATA: You can double that because I'm a newbie, too. So I think it's a great suggestion because I've been involved in collaboration between the Health Department, and I would suggest that -- I've written this down -- you know, other groups to collaborate on palliative care are AARP, ASTHMA, Alaska State Hospital and Nursing Home Association, Cancer Society, and including the American Heart Association, which also has a thing on palliative care, I believe. And if this -- you know, this seems like this would be something that could fall under your purview.

COMMISSIONER HARRELL: Or at the very least, just putting it out because you mentioned you're going to poll and develop consensus. So at least, it gives people an opportunity to comment.

MS. WOOLEY: I would just add that some of those folks we

will be reaching out to also on our Advisory Team, and even when we go out with surveys, with some of the existing -- because we'll start with some of the existing health objectives and what's going on, we're very aware that there are always, if you will, kind of late-breaking thoughts and ideas on where people are moving. So there will be an opportunity on all of those surveys for people to say, what did we miss, what has not been included in that? So that would be an opportune time also for the Commission, either as a whole or individually, to weigh in, if they're not seeing what they hope to see in the area of palliative care.

COMMISSIONER CAMPBELL: Well, our local medical staff, when they saw this on the agenda, said to bring back as much information as I can. So in that regard, I will do that. So they're interested -- but the medical staff is also a part of our Wellness for All program in the city. We've got about 35 people that meet monthly, and you know, set two-year goals and things like that for the community. And those are the kind of groups you're looking for to build upon from a local standpoint, right? Okay.

But I think this is a great idea to build the grass roots, if they're starting to talk about this at a local level.

MS. LEWIS: First, let me say that, you know, we welcome anybody who is interested. There is no limit to the size for

the Community of Interest, and if every Alaskan wanted to be part of it, we would be thrilled. So we certainly would encourage all the kinds of participation, and you know, to the extent that the entire Wellness for All group wanted to be part of the Community of Interest, you know, we kind of see two levels. There is the casual person who will come to the website and kind of browse around and then we expect that there is a group of Community of Interest. They won't be on the Advisory Team because there is a limited seat there, you know, of just 25 to 30, but there is more opportunity to engage in some other activities. So there sort of will be two levels there where you're, more or less, a registered Community of Interest person to say, I want newsletter, I want to know when meetings are going to be held, I want to be more involved. And so we'll have lots of opportunities there and that community base is going to be the make or break of the whole project.

COMMISSIONER MORGAN: I'm kind of moving to a different subject, and it's on the Advisory Team. My question is kind of an "A" and a "B." The first part is, do Municipal and Borough Health Departments have either a rep or they involved in this process?

MS. WOOLEY: Within the state of Alaska, we really have two of our municipalities with the (indiscernible - voice lowered), and yes, we are currently reaching out to the

Anchorage Municipality looking at theirs. We have many of the health care corporations that we -- we've reached out to a couple of those folks, too. So we absolutely are reaching out to the locals.

COMMISSIONER MORGAN: I'm going to help you on one of them. I chair or just -- and still -- I don't chair now. I've termed out, but I'm a member of the Municipality of Anchorage Health Commission. So within -- by Monday, you'll be getting a call, okay?

The second one is I'm in a bizarre situation in some ways. I represent community health centers, which there are programs, which are 23, which have about, depending on what day, 141 sites. Half the programs and 60% of the sites are tribal, which -- but there are 11 programs and about 42 sites that are not, and their public health interactions and problems are a little bit different. So my question -- that's -- the other part of my question is, the non-tribal community health center program and other primary care providers, are they -- do they have -- are they on the Core Team or how will that interaction work?

MS. WOOLEY: For the Advisory Team, we've also reached out to the Alaska Primary Care Association, trying to bring in that area, like we've reached out to ASHNHA that will be bringing in their expertise. So the challenge we have -- and we're certainly open to those suggestions -- is trying to keep

that Advisory Team at a small enough level that we can manage them and reach as many of the different areas. So often times, we have looked at some of the formal associations that represent a group, such as the Health Care Commission, to have that representation. So if you have specifics, we're.....

COMMISSIONER MORGAN: Speaking to the staff, all of one that's here, I would encourage for this -- I feel comfortable that we have plenty of tribal -- and to be clear, I'm employed by tribes, too, by tribal. I think I feel comfortable that we have probably the most tribal interaction in this than probably any place, maybe with the exception of North Dakota -- there's always one, you know, Oklahoma or something. But I'm a little -- I do think we need to make sure that the non-tribal community health programs and the municipal health departments are involved. I know the Anchorage -- because I had to sit there and read the thing two years ago and sign off on it. They do sort of this, but on the municipal level, and they have a whole building full of nurses, and they do stuff. And so I would hope -- and I will make sure that you get an answer. They're in transition, too. Their E.D. -- their Director has retired. They're in the process of selecting a new director, and the Municipal Health Commission will probably help the Mayor and the Assembly in that process. So I will -- I will make that commitment that I will make sure that either the Deputy or their Health Planner is aggravating

you, you know, calling you up and saying we want to be part of that, okay?

MS. WOOLEY: We welcome that aggravation.

COMMISSIONER MORGAN: I think it's great. I was kind of involved in the '10 from the low municipal level, and this is much better. This will produce a document that's useful, not -- I have one. I actually brought it. I brought mine. Yes; I brought mine, too. And I've gone through it, and I would say, well, what about this, what about this, what about -- you know, there is a lot of "what about this" that's not in there. This time, there will be virtually none of those, I don't think, by the way it's structured, but it's going to be a lot harder than having some academics get together and professional planners. That's it. Not people that deliver. Not people that report to assemblies or Ward that reports to a commission. You know, not really digging into it. So good luck, and boy, you must be very efficient to do it on the budget you've got; that's all I know.

MS. WOOLEY: We're leveraging every resource we can find.

COMMISSIONER STINSON: I grew up in Alaska, and looking at a lot of what you have listed are the same things I have seen for years and years and years. And suicide is horrendous. It's all over. It's particularly in the Bush, if you're going to look at per capita. But all of the other things -- behavioral health -- not to steal anything from

Emily -- and I'm sure, when I see the Steering Team, the people that you have on it, you have outstanding people. Jay is great. You have some really good people. It always seems -- it gets back to behavioral health issues for Alaska for now and in the future, if you're going to make one of the biggest impacts, if you're going to help the young people. I mean, I agree with the diabetes and the obesity, and obviously, we have to attend to those, but when you're losing people to violence, you're losing people to drugs and alcohol and suicide is just devastating up here. And I totally agree with the hospice type care. We have to do that, too. But behavioral health, I hope that that's being hammered.

MS. LEWIS: On the Advisory Team, we do have a representative actually confirmed, one of them, Delisa Culpepper with the Mental Health Trust Authority and so you know that she'll bring that strongly. And we also have a member of the Tribal Behavioral Health Directors Committee. So we're getting folks at those levels who can speak across the board. And so yes. And I think that we'll also -- I will be surprised, particularly coming from the tribal side -- because there are some that are really picking it up, the whole ACES and the Adverse Childhood events and so these will be -- what I expect to see -- you know, I won't be the deciding one bringing all of these forward, but I think that we will see a lot of that, just because of the increased

knowledge that we've gained through research in just even the last five years, let alone the ten to 12 years, of how this really impacts all aspects of our lives and chronic diseases.

COMMISSIONER STINSON: A follow-up with the emphasis on telemedicine. There is a psychiatrist at the University of Washington who I know has come up here before, gone to the villages, and has done a lot with psychiatry and telepsychiatry, and I'm going to be meeting with him and two others that have just recently joined him. Do you have any capability or interest in something along those lines?

MS. LEWIS: Well, I think I can speak to that a little bit. Within Healthy Alaskans 2020, we -- health information technology, public health infrastructure is listed, right now, as one of the proposed topic areas that we'll be working with, but outside of Healthy Alaskans 2020, the National Public Health Performance Improvement grant that Beverly and I are working with, one of the things that the State is doing with its tiny amount of money is funding a person in the Division of Public Health, who is a Telehealth and Health Information Exchange Coordinator. We have a State Health Information Exchange Coordinator. This -- so our person is different from that. We're not trying to lead a statewide effort in any way. What we're trying to do is to support that statewide effort through systems approaches in the public health agency, itself, to improve our own infrastructure, but also to help

employers to adopt telemedicine, you know, try and break down some of the obstacles and work with the State Coordinator on that. So you know, I can certainly put you in touch with that person who would be delighted to be of assistance in any way.

COMMISSIONER DAVIDSON: I just wanted to reflect where we were then. I think the 2010 document is really huge, and I'm guessing that many folks who have theirs brought theirs from the shelf where it sat for many years, and the nice thing about it being such a thick document is it could be used as weapon in case of intruder, but I really appreciate the transition from it being a weapon to an interactive tool that is alive and living and breathing that people at the community level can actually use because it's going to be posted on the Web. And I guess the only caution that I would have is making sure that, as that gets out, not everybody is computer savvy, and I know you're champs at making sure that we can post something at the post office or the tribal hall or the community hall, just to make sure that -- you know, they may not be Internet savvy, but I bet they have a niece or a nephew or a daughter or a granddaughter or grandson who is. So good job.

MS. LEWIS: Thank you for that. We're hoping that that's going to be a much more useful tool, also that, as things develop over a decade, you don't always have the same objectives and priorities or you have new indicators that came

out, and with the book, you can't really go back and fix that, but with the website, we can stay much more timely. And also we're hoping that, if this is successful in both our process and our product, we don't have to start from square one to do 2030, that we will be able to refresh this project rather than start from scratch. So you know, I thank you for that. And we are being very cognizant of the limitations of a Web-based system. So we'll have some paper-based options and also a strong consideration for bandwidth issues in the rural areas in how we're designing the Web.

MS. WOOLEY: Well, and even trying to get things out through Facebook and Twitter, you know, so again, that will hit some of the kids in the area that then will be able to bring their aunties and others along and share that kind of information with them and also from the tribal side. With the epidemiology center, we have funded a position within that area, and we've actually started going out to the regions and providing to the regions this data update as kind of a precursor getting us going with the commitment that we've got to keep going out in person and engaging people because it's so easy to put that book up on the shelf because we're all so busy, but when we get out and we actually engage person-to-person, what we're finding is we're getting very spirited and engaged dialogue. So there will be an emphasis to do as much of that as we can within our own organizations and across.

COMMISSIONER ERICKSON: There was a companion piece to this that was done that was -- and I can't remember exactly what it was called, but it was -- and I know -- did that seem too threatening to pick that up, pick up the weapon and hold it that way? I'm sorry. But the companion piece took -- I don't know if it took all 26 areas, but it took some of the areas and told community stories from Alaska of grass roots based groups at the community level working to address particular issues. And so it was meant to provide an example and to provide some stories, and we talked a little bit yesterday about the value of telling stories. So I mean, there weren't as many published, and it wasn't as useful of a weapon. It wasn't as thick. So I don't see it around hardly ever, except for on my shelf.

So a recommendation as you develop the website, maybe there could be a story piece of, you know, communities that are doing innovative things to address some of these health challenges at a local level and stories about what's happening at the state level to address statewide issues.

MS. LEWIS: Well, that is a great point, Deb, and the stories were found to be quite valuable by folks. Healthy Alaskans 2010 is part of the curriculum for the Master's of Public Health program and that's one of the pieces that they use extensively in their training, and as a matter of fact, outside of -- sort of ancillary to what we're doing, they are

going to take on that piece. We don't actually have the money this time to do that kind of effort with our limited resources and so we're leveraging and we're -- the University is going to take that on and create that piece, and I think your idea of making sure that there is a dynamic way on the website to continue to gather these stories is an excellent one.

MS. WOOLEY: One of the other things we're working with -- I've started talking with some of the folks again at ANTHC. We do a lot of what's called digital stories, and we bring groups in from around the state, and they actually bring in their photos, and we help them to put it together, and it goes up then on the Web. And so it's the voice -- and they voice over these. They take stills and then they put it together and voice over. We've used a lot with providing health education, if you will, people telling in their own story why they went and got a colonoscopy and that it's okay to do that and why perhaps a mammogram or take the different -- so that -- in fact, I just talked with Gary Ferguson the other day, saying, you know, with what we're doing, they did stories -- I think there is going to be a way that we'll bring that in. So again, excellent because we all like stories.

COMMISSIONER ERICKSON: If -- what's.....

COMMISSIONER URATA: Do you have any questions for us about what we could do or provide?

MS. WOOLEY: I think that's what we're here for. I mean,

truly, part of our question to you is, what do you know with what you're doing that can help us out? Certainly, one of the things that we would ask of you, as you go back to your agencies and the different groups that you work with, as you start to see in early September, mid-September, the roll out of involvement with the Community of Interest that, both, you know, again either as a Commission, individually, back with your organizations, or in your communities, you're encouraging that, and if you will, kind of championing the process because, as the slide shows, if the foundation crumbles, if we can't actually engage that Community of Interest, and make them feel that they're valued, that we're listening to them, and that what's important to them is important to us and that's what we want to work on, it won't work. So that's one of the areas we know, but we would be happy to hear suggestions of other ways that you would be able to engage and work with us.

MS. LEWIS: And I'd like to add to that. Because, you know, we recognize that the Health Care Commission has a certain responsibility for recommendations for a statewide health improvement plan, I think that we're hoping is that you will see Healthy Alaskans 2020 as a very integral and key part of what that plan is because, you know, we will have the targets, the indicators, the strategies, and moving into the final phase, you know, an actual implementation plan of how to

keep this going on. And so you know, to the extent that we can help fulfill that role for the Health Care Commission, you know, we would be very open to discussing how we might be able to assist in that and how we might fit into what you see that being and how you just see that fitting into what your goals are for yourselves.

CHAIR HURLBURT: Yeah. I think, if -- and I know both Deb and Jill, you both have been talking with Deb on this issue, but I think taking the three annual reports and soon to be working on the fourth one, they identify areas of focus that the Commission has identified each year and have focused on, and I think that can be helpful with ways that they've already been articulated as far as issues that have come up over the past three-and-a-half years now with the Commission.

MS. WOOLEY: I think that's really appropriate, Dr. Hurlburt, particularly as we've said we don't want to recreate things. We're going to go back and look at other plans that are out there, assessments, and that would fit right in with that area to be able to do that, and you said, we've been working really closely with Deb just on a variety of things, so again, kind of that right hand knowing what the left hand is doing, and we'll look forward to getting more of that.

COMMISSIONER ERICKSON: One of the things that we're still struggling, all of us are still struggling a little bit with just in terms of process and product from all of the

planning stuff is just exactly what this new statutory authority for the Department to create a state health plan based on the recommendations of the Commission means. Conversations I've been having with the Commissioner about what that means to him, and more recently, he had said, you know, well, I really see the kind of culmination or transition point plan in 2014 coming from the Commission as the state health plan. And so then what does that mean for Healthy Alaskans 2020?

Our Chair is a member with the Commission of Health and Social Services of the Steering Team for Healthy Alaskans 2020. I tried to get some more clarity. I'm not making fun of the Commissioner. I'm making fun of me. I put together a bunch of diagrams and went and met with him, trying to diagram all of these different planning activities that go on and how -- you know, whether -- what the Commission is doing is providing an umbrella or a framework or -- and how all of our pieces relate together, and I just happened to be sitting down with him. It was probably about 20 minutes before the Governor released his press release about the Insurance Exchange. And he looked at me, and he looked at my diagrams, and he looked at me, and he looked at my diagrams, and he looked at me, and he said, I don't like purple. And I went, maybe we should talk another day.

So we're continuing that conversation, so the

conversation we just had with the Commissioner about the Affordable Care Act and the relationship with the Commission. As we struggle, I'm pulling all of these pieces together. I think one of the other roles in our statutory charge for the Commission is to be the Health Planning Coordinator for the State, and we have not taken that -- we have not defined that to mean every organization in the state involved with health planning has to come before us and present their plans to us and we're going to coordinate this somehow for them. But what we're doing is we're having these conversations to make sure we're not duplicating efforts and that we're trying to align, as much as possible, activities. And I included the most recent copy of the inventory that we're maintaining of all of the -- or at least, the past years of plans and reports about statewide health issues.

And just a reminder, too, for the group with our new Vision Statement that we defined at the Commission's last meeting is that -- and I can't remember now if I shared this with you guys, Lisa and Bev and Jill. I think I did. By 2025, Alaskans will be the healthiest people in the nation -- so that's the Commission's vision now -- and have access to the highest quality, most affordable health care. And then we have three core measures that we'll measure our vision against and want to work on defining that next level down. So we're just going to be working together on this vision.

MS. LEWIS: Deb, one thing I wanted to add about the health plan's list that you folks maintain is that's one of the pieces that we'll be bringing in to the website so that, you know, as people go to the website and they, you know, look for a topic of interest and drill down to an objective and then find a leading health indicator or another indicator and then evidence-based strategies, they will also be able to see, you know, where does this show up in other state health plans that have been created. So again, you know, bringing all that information and all that work that's already been done, so that we're not reinventing the wheel because I think it really strengthens -- say if you were a grantee, you know, it could strengthen your application to say, well, I happen to know that this thing is also a priority for the American Cancer Society and the United Way and those kinds of things, too. So that's another way that we'll be bringing in some of the work that you folks have already done.

MS. WOOLEY: Leveraging resources.

CHAIR HURLBURT: Any other comments or questions on this? We appreciate your coming. We appreciate you doing this. And I think the approach that it's not the state government doing it by itself, but it's the community and the state -- because, as Jill pointed out, looking at the Healthy Alaskans 2010, there were some successes and others of what you might call failures, but not necessarily really failures. The whole

process, as I've seen year-by-year with us doing it now in Alaska for the third time, but the country doing it longer, has identified issues, has identified goals. Sometimes they've been a little unrealistic, but they've been very helpful to refer to. So we appreciate your doing this.

We want to wrap up now. Everybody, I think, has in mind that our next meeting is going to be in October. The focus will be on employers, mostly private sector employers and the challenges they're facing. You've been provided with the book that I would urge everybody to read. It reads pretty quickly. It's an easy book to read. So it doesn't take any -- take long. For those of you who didn't get through *Tracking Medicine*, I would say that's more the encyclopedic part and dealing with it, and it's a book I still highly recommend for those of us who are really getting into this whole area. But I think that we'll have a unique opportunity there, as Deb mentioned earlier, with the noontime meeting with our guest speaker, co-sponsored with Commonwealth North. There will be large participation. I don't remember, other than Deb and me, if anybody was in the recent Commonwealth North luncheon meeting. David, yeah; you were there. I saw you.

COMMISSIONER MORGAN: I'm a member because I join everything. So I would suspect between the health care, insurance underwriters, Commonwealth North, Chamber of Commerce, I would not be surprised if it will be one of the

largest meetings, luncheon meetings they've ever had. In the business community, I actually had seen him and heard him in another conference in the Lower 48. He's well -- this guy is well-known, and I think it will be of great interest. I got my -- I'm going to have him sign mine, my book, from when I bought it two years ago. So anyway, but I would -- Deb, are you registering us as a group or should we -- how are we going to work that?

COMMISSIONER ERICKSON: Everybody, but you. No. The Commission members will have tickets to the luncheon, and the next Commission meeting will actually be held at the Hilton because that was the venue that we could identify as both Commonwealth North could use for their luncheon forum. It's a busy time of year for conventions. And so we'll actually be having our meeting there. For the speech that we're co-hosting with Commonwealth North, we'll be going to the ballroom next door for that. It will be a luncheon speech, but our meeting will be held in the same facility, and we're going to have some follow-up similar to what we've done at this meeting with kind of the outside keynote speaker followed by some panels of Alaskans talking about opportunities and barriers and things that are happening in Alaska related to what employers are doing to engage in improving outcomes and quality and cost of health care. So we will -- it should be a good event. It's pretty exciting stuff. A lot going on. And

we will be buying tickets for you all for that event.

For those of you who are travelers, we'll follow-up after this meeting on logistics, whether we have rooms reserved for our traveling Commission members there or not and if you want to stay there or not.

Other than that, we are going to have a very full agenda at this next meeting and so we'll try to do more in writing. Between now and that next meeting, you're going to see more communication than you're used to for me over the next couple of months. So keep an eye out for that. And we might even try to hold a teleconference or two. We haven't done that for a while, and we've been able to get a lot of work done in the past on those teleconferences.

CHAIR HURLBURT: Let me just maybe finish where I was going on the last meeting that David was in and Deb and I there. I think they'll be primed because they did have the representatives of four corporations here in town. Tom Haupt (ph) was there from Providence, Alyeska Pipeline, GCI, and NANA. And particularly with the NANA provider groups, the corporations, this is clearly -- this whole area is a major issue for them, a major challenge to them. And I think that the community is ripe for looking at innovative changes. The employers are clearly interested, in a humanistic way, in meeting the needs of their employers, but are just being bled on the costs now. So I think it's an opportunity to look at

quality. I think our speaker -- for those of you have read his book, you'll see that he's talking about issues of access. He's talking about quality. He's talking about costs. He's talking about shared and common interests.

So I think, just as this meeting was, which I am so glad that Deb captured with the video-conference yesterday because I think was superb, and I think you will find the next meeting to be as well. Deb?

COMMISSIONER ERICKSON: Just any final questions or comments before we adjourn today?

CHAIR HURLBURT: Any process comments or comments on this meeting?

COMMISSIONER ERICKSON: Suggestions for improvement for next time?

COMMISSIONER MORGAN: Please thank Providence. This was well done, I thought.

COMMISSIONER ERICKSON: Thank you. That's an excellent point. I was just thinking, this morning driving in, that I needed to, at least, write a thank you card to them, but if there's anybody from.....

COMMISSIONER MORGAN: I move we adjourn.

COMMISSIONER ERICKSON: Second.

(Off record)

END OF PROCEEDINGS